INVITATION TO BID NO: 10-X-2205737

STATE OF ALABAMA

DEPTARTMENT OF FINANCE
DIVISION OF PURCHASING

INVITATION TO BID

REQ. AGENCY : 062000
ALABAMA MEDICAID AGENCY
AGENCY REQ. NO. :
T-NUMBER : TA001
DATE ISSUED : 03/10/10
VENDOR NO. :
VENDOR PHONE NO. :
SNAP REQ. NO. : 1415226
BUYER NAME : RAY BRESSLER

FOR: FISCAL AGENT SERVICE
MEDICAID

BUYER PHONE NO. : (334) 242-4670-
PURCHASING PHONE NO: (334) 242-7250

BID MUST BE RECEIVED BEFORE:
DATE: 05/11/10 TIME: 5:00 PM

BIDS WILL BE PUBLICLY OPENED:
DATE: 05/12/10 TIME: 10:00 AM

TO BE COMPLETED BY VENDOR

INFORMATION IN THIS SECTION SHOULD BE PROVIDED, AS APPROPRIATE. BID RESPONSE MUST BE IN INK OR TYPED WITH ORIGINAL SIGNATURE AND NOTARIZATION.

1. DELIVERY: CAN BE MADE _____ DAYS OR _____ WEEKS AFTER RECEIPT OF ORDER

2. TERMS: _____(DISCOUNTS ARE TAKEN WITHOUT REGARD TO DATE OF PAYMENT.)

3. PRICE VALID FOR ACCEPTANCE WITHIN _____ DAYS.

4. VENDOR QUOTATION REFERENCE NUMBER, IF ANY: _____
(THIS NUMBER WILL APPEAR ON THE PURCHASE ORDER.)

5. E-MAIL ADDRESS: _____

INTERNET WEBSITE: _____

6. GENERAL CONTRACTOR'S LICENSE NO: _____

TYPE OF G.C. LICENSE: _____

***** IMPORTANT NOTE: *****
BIDDERS MUST COMPLY WITH ALL "BID RESPONSE INSTRUCTIONS" ON PAGE 2, TO INCLUDE ITEM 7 - COPY REQUIREMENT.

RETURN INVITATION TO BID:

US MAIL

STATE OF ALABAMA
DEPARTMENT OF FINANCE
DIVISION OF PURCHASING
P O BOX 302620
MONTGOMERY, AL 36130-2620

COURIER

STATE OF ALABAMA
DIVISION OF PURCHASING
RSA UNION BUILDING
100 N. UNION ST., SUITE 192
MONTGOMERY, AL 36104

SIGNATURE AND NOTARIZATION REQUIRED

I HAVE READ THE ENTIRE BID AND AGREE TO FURNISH EACH ITEM OFFERED AT THE PRICE QUOTED. I HERBY AFFIRM I HAVE NOT BEEN IN ANY AGREEMENT OR COLLUSION AMONG BIDDERS IN RESTRAINT OF FREEDOM OF COMPETITION BY AGREEMENT TO BID AT A FIXED PRICE OR TO REFRAIN FROM BIDDING.

SWORN TO AND

SUBSCRIBED BEFORE ME THIS

_____ DAY OF _____

_____
NOTARY PUBLIC

TERM EXP: _____

_____
FEIN OR SSN

_____
COMPANY NAME

_____
MAIL ADDRESS

_____
CITY, STATE, ZIP

_____
PHONE INCLUDING AREA CODE

_____
AUTHORIZED SIGNATURE (INK)

_____
TYPE/PRINT AUTHORIZED NAME

_____
TITLE

_____
TOLL FREE NUMBER

_____
FAX NUMBER

STANDARD TERMS & CONDITIONS

VENDOR NAME :

VENDOR NUMBER: -

ITB NO. : 10-X-2205737 PAGE 2

INVITATION TO BID

OPEN DATE : 05/12/10 TIME: 10:00 AM

T-NUMBER : TA001

RETURN DATE: 05/11/10 TIME: 5:00 PM

AUTHORITY:
THE DEPARTMENT OF FINANCE CODE OF ADMINISTRATIVE PROCEDURE, CHAPTER 355-4-1 EFFECTIVE DECEMBER 20, 2001 IS INCORPORATED BY REFERENCE AND MADE A PART OF T HIS DOCUMENT. TO RECEIVE A COPY CALL (334)242-7250, OR OUR WEBSITE WWW.PURCHASING.ALABAMA.GOV .

INFORMATION AND ASSISTANCE TO MINORITY AND WOMEN-OWNED BUSINESSES IN ACQUIRING M/WBE CERTIFICATION MAY BE OBTAINED FROM THE OFFICE OF MINORITY BUSINESS ENTERPRISE, 1-800-447-4191.

BID (ITB) RESPONSE INSTRUCTIONS REV: 01/14/10

1. TO SUBMIT A RESPONSIVE BID, READ THESE INSTRUCTIONS, ALL TERMS, CONDITIONS AND SPECIFICATIONS.

2. BID ENVELOPES/PACKAGES/BOXES MUST BE IDENTIFIED ON FRONT, PREFERABLY LOWER LEFT CORNER AND BE VISIBLE WITH THE BID NUMBER AND OPENING DATE. EACH INDIVIDUAL BID (IDENTIFIED BY A UNIQUE BID NUMBER) MUST BE SUBMITTED IN A SEPARATE ENVELOPE. RESPONSES TO MULTIPLE BID NUMBERS SUBMITTED IN THE SAME ENVELOPE/COURIER PACKAGE, THAT ARE NOT IN SEPARATE ENVELOPES PROPERLY IDENTIFIED, WILL BE REJECTED. THE DIVISION OF PURCHASING DOES NOT ASSUME RESPONSIBILITY FOR LATE BIDS FOR ANY REASON INCLUDING THOSE DUE TO POSTAL, OR COURIER SERVICE. BID RESPONSES MUST BE IN THE DIVISION OF PURCHASING OFFICE PRIOR TO THE "RECEIVE DATE AND TIME" INDICATED ON THE BID.

3. BID RESPONSES (PAGE 1, PRICE SHEET AND ADDENDUMS (WHEN SIGNATURE IS REQUIRED)) MUST BE IN INK OR TYPED ON THIS DOCUMENT. OR EXACT FORMAT WITH SIGNATURES BEING HANDWRITTEN ORIGINALS IN INK (PERSON SIGNING BID, NOTARY, AND NOTARY EXPIRATION), OR THE BID WILL BE REJECTED. UNLESS INDICATED IN THE BID, ALL PRICE PAGES MUST BE COMPLETED AND RETURNED. IF AN ITEM IS NOT BEING BID, IDENTIFY IT AS NB (NO-BID). PAGES SHOULD BE SECURED. THE DIVISION OF PURCHASING DOES NOT ASSUME RESPONSIBILITY FOR MISSING PAGES. FAXED BID RESPONSES WILL NOT BE ACCEPTED.

4. THE UNIT PRICE ALWAYS GOVERNS REGARDLESS OF THE EXTENDED AMOUNT. A UNIT PRICE CHANGE ON A LINE MUST BE INITIALED BY THE PERSON SIGNING THE BID, OR THAT LINE WILL BE REJECTED. THIS INCLUDES A CROSS-OUT, STRIKE-OVER, INK-OVER, WHITE-OUT, ERASURE, OR ANY OTHER METHOD CHANGING THE PRICE.

5. A "NO BID" MUST BE RETURNED TO REMAIN ON A CLASS/SUBCLASS. RETURN PAGE 1 OR NOTIFICATION PAGE MARKED "NO-BID". IDENTIFY IT ON THE ENVELOPE AS A "NO-BID". FAILING TO RESPOND TO 3 ITB'S WITHIN THE SAME CLASS/SUBCLASS WILL AUTOMATICALLY PURGE THE VENDOR FROM THAT CLASS/SUBCLASS. RESPONDING WITH 6 "NO-BIDS" WITHIN THE SAME CLASS/SUBCLASS WILL AUTOMATICALLY PURGE THE VENDOR FROM THAT CLASS/SUBCLASS. A "NO-BID" RECEIVED LATE IS CONSIDERED A NO RESPONSE.

6. THE DIVISION OF PURCHASING IS NOT RESPONSIBLE FOR MISINTERPRETATION OF DATA FAXED FROM THIS OFFICE.

7. THE DIVISION OF PURCHASING REQUIRES AN ORIGINAL AND A MINIMUM OF ONE COMPLETE EXACT COPY (TO INCLUDE SIGNATURE AND NOTARY) OF THE INVITATION-TO-BID RESPONSE. THE ORIGINAL AND THE COPY SHOULD BE SUBMITTED TOGETHER AS A BID PACKAGE. FAILURE TO MARK RESPONSES AS "ORIGINAL" AND/OR "COPY" COULD RESULT IN THE ENTIRE BID RESPONSE BEING REJECTED.

8. AN IMPROPERLY SUBMITTED BID, LATE BID, OR BID THAT IS CANCELLED ON OR BEFORE THE OPENING DATE WILL BE HELD FOR 90 DAYS AND THEN DESTROYED. THE BID MUST BE RETRIEVED DURING REGULAR WORK HOURS, MONDAY - FRIDAY, EXCEPT STATE HOLIDAYS. AFTER THE BID IS DESTROYED, THE DIVISION OF PURCHASING ASSUMES NO RESPONSIBILITY FOR THE DOCUMENT.

DISQUALIFIED/CANCELLED BID

BIDS THAT ARE IMPROPERLY SUBMITTED OR RECEIVED LATE WILL BE A RESPONSE FOR RECORD, BUT WILL NOT BE RETURNED OR A NOTIFICATION MAILED.

THE FOLLOWING IS A PARTIAL LIST WHEREBY A BID RESPONSE WILL BE DISQUALIFIED:

BID NUMBER NOT ON FACE OF ENVELOPE/COURIER PACKAGE/BOX
RESPONSES TO MULTIPLE BID NUMBERS IN SAME ENVELOPE NOT PROPERLY IDENTIFIED
BID RECEIVED LATE
BID NOT SIGNED/NOT ORIGINAL SIGNATURE
BID NOT NOTARIZED/NOT ORIGINAL SIGNATURE OF NOTARY AND/OR NO NOTARY EXPIRATION
NOTARIZED OWN SIGNATURE
REQUIRED INFORMATION NOT SUBMITTED WITH BID
FAILURE TO SUBMIT THE ORIGINAL BID AND A COMPLETE EXACT COPY

CERTIFICATION PURSUANT TO ACT NO. 2006-557

ALABAMA LAW (SECTION 41-4-116,CODE OF ALABAMA 1975) PROVIDES THAT EVERY BID SUBMITTED AND CONTRACT EXECUTED SHALL CONTAIN A CERTIFICATION THAT THE VENDOR, CONTRACTOR, AND ALL OF ITS AFFILIATES THAT MAKE SALES FOR DELIVERY INTO ALABAMA OR LEASES FOR USE IN ALABAMA ARE REGISTERED, COLLECTING, AND REMITTING ALABAMA STATE AND LOCAL SALES, USE, AND/OR LEASE TAX ON ALL TAXABLE SALES AND LEASES INTO ALABAMA. BY SUBMITTING THIS BID, THE BIDDER IS HEARBY CERTIFYING THAT THEY ARE IN FULL COMPLIANCE WITH ACT NO. 2006-557, THEY ARE NOT BARRED FROM BIDDING OR ENTERING INTO A CONTRACT PURSUANT TO 41-4-116, AND ACKNOWLEDGES THAT THE AWARDING AUTHORITY MAY DECLARE THE CONTRACT VOID IF THE CERTIFICATION IS FALSE.

INTENT TO AWARD

EFFECTIVE MAY 1, 2008, THE STATE OF ALABAMA - DIVISION OF PURCHASING WILL ISSUE AN 'INTENT TO AWARD' BEFORE A FINAL AWARD IS MADE. THE 'INTENT TO AWARD' WILL CONTINUE FOR A PERIOD OF FIVE (5) CALENDAR DAYS, AFTER WHICH A PURCHASE ORDER WILL BE PRODUCED. UPON FINAL AWARD, ALL RIGHTS TO PROTEST ARE FORFEITED. A DETAILED EXPLANATION OF THIS PROCESS MAY BE REVIEWED IN THE ALABAMA ADMINISTRATIVE CODE - CHAPTER 355-4-1(14).

ALTERNATE BID RESPONSE

UNLESS STATED ELSEWHERE IN THIS INVITATION-TO-BID (ITB) THE STATE OF ALABAMA WILL ACCEPT AND EVALUATE ALTERNATE BID SUBMITTALS ON ANY ITB'S. ALTERNATE BID RESPONSES WILL BE EVALUATED ACCORDING TO THE REQUIREMENTS AS ALL OTHER RESPONSES TO THIS ITB.

INTERNET WEBSITE LINK'S

INTERNET AND/OR WEBSITE LINKS WILL NOT BE ACCEPTED IN BID RESPONSES AS A MEANS TO SUPPLY ANY REQUIREMENTS STATED IN THIS ITB (INVITATION-TO-BID).

PRODUCT DELIVERY, RECEIVING AND ACCEPTANCE

IN ACCORDANCE WITH THE UNIVERSAL COMMERCE CODE (CODE OF ALABAMA, TITLE 7), AFTER DELIVERY, THE STATE OF ALABAMA HAS THE RIGHT TO INSPECT ALL PRODUCTS BEFORE ACCEPTING. THE STATE WILL INSPECT PRODUCTS IN A REASONABLE TIMEFRAME. SIGNATURE ON A DELIVERY DOCUMENT DOES NOT CONSTITUTE ACCEPTANCE BY THE STATE. THE STATE WILL ACCEPT PRODUCTS ONLY AFTER SATISFACTORY INSPECTION.

SALES TAX EXEMPTION

PURSUANT TO THE CODE OF ALABAMA, 1975, TITLE 40-23-4 (A) (11), THE STATE OF ALABAMA IS EXEMPT FROM PAYING SALES TAX. AN EXEMPTION LETTER WILL BE FURNISHED UPON REQUEST.

INVOICES

INQUIRIES CONCERNING PAYMENT AFTER INVOICES HAVE BEEN SUBMITTED ARE TO BE DIRECTED TO THE RECEIVING AGENCY, NOT THE DIVISION OF PURCHASING

BID RESPONSES AND BID RESULTS

UNEVALUATED BID RESPONSES (NOT BID RESULTS) ARE AVAILABLE ON OUR WEB SITE AT WWW.PURCHASING.ALABAMA.GOV. BID RESULTS WILL BE MADE AVAILABLE FOR REVIEW IN THE DIVISION OF PURCHASING OFFICE, BUT ONLY AFTER THE BID HAS BEEN AWARDED. WE DO NOT FAX OR MAIL COPIES OF BID RESULTS. IF A VENDOR WISHES TO REVIEW BID RESULTS IN OUR OFFICE, THEY SHOULD FAX THEIR REQUEST TO REVIEW THE BID TWO DAYS IN ADVANCE TO THE "BID REVIEW CLERK" AT (334) 242-4419. BE SURE TO REFERENCE THE BID NUMBER.

FOREIGN CORPORATION - CERTIFICATE OF AUTHORITY

ALABAMA LAW PROVIDES THAT A FOREIGN CORPORATION (AN OUT-OF-STATE COMPANY/FIRM) MAY NOT TRANSACT BUSINESS IN THE STATE OF ALABAMA UNTIL IT OBTAINS A CERTIFICATE OF AUTHORITY FROM THE SECRETARY OF STATE. SECTION 10-2B-15.01, CODE OF ALABAMA 1975. TO OBTAIN FORMS FOR A CERTIFICATE OF AUTHORITY, CONTACT THE SECRETARY OF STATE, CORPORATIONS DIVISION, (334) 242-5324. THE CERTIFICATE OF AUTHORITY DOES NOT KEEP THE VENDOR FROM SUBMITTING A BID.

BID IDENTIFICATION

REFERENCE PAGE 2, ITEM 2. DUE TO THE POSTAL SERVICE PUTTING BAR CODE LABELS ON ENVELOPES, IT CONCEALS THE BID NUMBER AND DATE IF THE VENDOR HAS WRITTEN THEM OTHER THAN THE LOWER LEFT CORNER, THEREFORE THE BID WOULD BE REJECTED FOR NOT BEING PROPERLY IDENTIFIED.

VENDOR NAME :

VENDOR NUMBER: -
ITB NO. : 10-X-2205737
OPEN DATE : 05/12/10 TIME: 10:00 AM
T-NUMBER : TA001
RETURN DATE: 05/11/10 TIME: 5:00 PM

AWARD:
AWARD WILL BE MADE "ALL OR NONE" TO THE LOWEST RESPONSIBLE BIDDER MEETING ALL SPECIFICATIONS.

BLANK LINES:
TO EVALUATE THE BID IN AN EFFICIENT MANNER, THE VENDOR SHOULD FILL-IN ALL BLANK LINES APPLICABLE TO A SPECIFIC COMMODITY DESCRIPTION.

VENDOR NAME :

VENDOR NUMBER: -
ITB NO. : 10-X-2205737
OPEN DATE : 05/12/10 TIME: 10:00 AM
T-NUMBER : TA001
RETURN DATE: 05/11/10 TIME: 5:00 PM

THE FOLLOWING CONFERENCES WILL BE HELD

CONFERENCE	LOCATION
MANDATORY PRE-BID CONFERENCE DATE: 04/01/10 TIME: 10:00 AM	STATE OF ALABAMA/ FINANCE DEPT PURCHASING DIVISION AUDITORIUM 100 N UNION ST / SUITE 192 MONTGOMERY AL 36104

PRICE SHEET

VENDOR NAME :

VENDOR NUMBER: -
ITB NO. : 10-X-2205737 PAGE 6
INVITATION TO BID OPEN DATE : 05/12/10 TIME: 10:00 AM
T-NUMBER : TA001
RETURN DATE: 05/11/10 TIME: 5:00 PM

LINE NO.	COMMODITY/SERVICE DESCRIPTION	QUANTITY	UNIT	UNIT PRICE	EXTENDED AMOUNT
	UNLESS SPECIFIED OTHERWISE BELOW: SHIP TO: R1 / STATEWIDE				
00001	COMMODITY CODE: 946-49-074410 FISCAL AGENT, ALABAMA MEDICAID AGENCY IN ACCORDANCE WITH PROVIDED SPECIFICATIONS, TERMS AND CONDITIONS. NOTE: "LOT" UNIT PRICE INCLUDES BOTH THE IMPLEMENTATION COST (INITIAL SET-UP,ETC) AND THE OPERATIONAL COSTS FOR SEVEN (7) YEARS STARTING 10-01-11 PER ATTACHED SPECIFICATIONS. THE PRICING WILL BE ENTERED ON EXCEL SHEETS PROVIDED AT THE MANDATORY PRE-BID CONFERENCE 04-01-10 AT 10:00 AM IN PURCHASING AUDITORIUM, 100 N UNION/ SUITE 192, MONTGOMERY AL 36104. THE TOTAL PRICE OF THE CONTRACT MUST BE WRITTEN ON UNIT PRICE-BLANK LINE FILL-IN PROVIDED ON PRICE SHEET (EXTENDED PRICE WILL BE SAME AMOUNT AS UNIT PRICE). FAILURE TO TO PROVIDE A UNIT PRICE ON PRICE SHEET OF BID FORM AND RETURN OF COMPLETED EXCEL DISCS (11 DISCS ARE REQUIRED - ONE FOR ORIGINAL BID, TEN BID COPIES FOR AGENCY EVALUATION) WILL CAUSE BID TO BE REJECTED. PLEASE EMAIL ANY QUESTIONS TO THE BUYER RAY.BRESSLER@PURCHASING.ALABAMA.GOV ;CC TO PAUL.BRANNAN@MEDICAID.ALABAMA.GOV ********** R E M E M B E R : R E T U R N T E N C O M P L E T E E X A C T C O P I E S O F B I D W I T H O R I G I N A L B I D T O B E C O N S I D E R E D F O R A W A R D ********** PLEASE READ ENTIRE BID/ SPECIFICATIONS THOROUGHLY, ESPECIALLY BID INSTRUCTIONS ON PAGE 2 AND REMEMBER THAT PRE-BID CONFERENCE 04-01-10 AT 10AM IS MANDATORY AT RSA UNION BLDG 100 N UNION / STE 192 NOTE: PAGE 2 ITEM 7 SAYS ORIGINAL BID AND ONE COMPLETE EXACT COPY TO BE RETURNED - THIS PARTICULAR BID REQUIES TEN (10) COMPLETE EXACT COPIES INCLUDING COMPLETED EXCEL DISCS PER ATTACHED SPECIFICATIONS. SHIP TO: 062000 / 062M01 ALABAMA MEDICAID AGENCY	1	LOT	_____	_____
	PAGE TOTAL				_____

PRICE SHEET

VENDOR NAME :

VENDOR NUMBER: -

INVITATION TO BID

ITB NO. : 10-X-2205737 PAGE 7
OPEN DATE : 05/12/10 TIME: 10:00 AM
T-NUMBER : TA001
RETURN DATE: 05/11/10 TIME: 5:00 PM

LINE NO.	COMMODITY/SERVICE DESCRIPTION	QUANTITY	UNIT	UNIT PRICE	EXTENDED AMOUNT

MEDICAID AGENCY
ROOM 1012
501 DEXTER AVE
MONTGOMERY AL 36104

PAGE TOTAL _____

BID TOTAL _____

Invitation to Bid #10-X-2205737

for

Fiscal Agent Contract Procurement

for

Takeover and Enhancement of the

Medicaid Management Information System

Submitted

March 2010

by

Alabama Medicaid Agency

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ADMINISTRATIVE INFORMATION

1.01 Issuing Office

The Invitation to Bid (ITB) is issued by the State of Alabama, Department of Finance, Division of Purchasing for the Alabama Medicaid Agency. Pursuant to the provisions of the Code of Alabama, 1975, Section 41-16-20 through 41-16-32, and Section 22-6-7, the Alabama Medicaid Agency, hereinafter called the Agency, solicits sealed bids for a fiscal agent (Vendor) for the Alabama Medicaid Program.

1.02 Invitation to Submit Bids

The State of Alabama provides prospective Bidders with sufficient information to enable them to prepare and submit bids for consideration by the Agency to satisfy the need for expert assistance in the completion of the goals and requirements of this ITB. All interested Bidders who were not contacted are invited to submit a proposal in accordance with the rules, procedures and dates set forth herein. In the event of "No Bid," please sign the State of Alabama, Invitation to Bid form, indicating "No Bid" and return to the State of Alabama, Department of Finance, Division of Purchasing. All bids submitted pursuant to this request shall be made in accordance with the provisions of the State of Alabama Department of Finance, Division of Purchasing.

1.03 Purpose

It is the intent of the Agency to provide prospective Bidders with sufficient information to enable them to prepare and submit proposals. These proposals shall demonstrate the Vendor's ability to satisfy the need for vendor services to implement an enhanced Alabama Medicaid Management Information System (AMMIS) for the Agency, to address Alabama-specific requirements, and to perform Vendor responsibilities as defined in this ITB. The Vendor shall be responsible for performance of all duties specified within this ITB for the amount of compensation quoted in its response to this ITB.

1.04 Scope

The ITB contains numerous instructions governing proposal submission requirements and the material to be included therein. These are mandatory responsiveness requirements that must be met to be eligible for consideration.

Bid responses shall be submitted consistent with the format and content specified in *Section 4 – Bidder Response Format*.

A mandatory responsiveness requirements checklist for bid responses is provided in *Section 7.10 - Appendix J – Responsiveness Requirements Checklist*. Failure, in whole or in part, to respond to a specific mandatory requirement shall result in rejection of the

Vendor's bid as non-compliant with the ITB requirements during the evaluation process or at any time that such deficiency is discovered. The Agency at its sole discretion reserves the right to waive minor irregularities.

The Agency reserves the right to reject any and all bids submitted in response to this ITB.

Subsequent to the opening of the sealed bids, discussions may be conducted by the Agency and the Division of Purchasing with Bidders for the purpose of clarification to assure full understanding of and responsiveness to the solicitation requirements. Bidders shall be accorded fair and equal treatment with respect to any opportunity for discussion. Where it appears that a proposal submitted fails to meet mandatory responsiveness requirements, the Agency reserves the right to determine compliance of the Bidder.

1.05 Schedule of Activities

1.05.01 Procurement Timetable

The following timetable is anticipated for the procurement process:

	Activity	Date	Central Time
1.	Deadline for Submitting Questions to be Answered at the Pre-Bid Conference	Five (5) Business Days before Pre-bid Conference	5:00 P.M.
2.	Mandatory Pre-Bid Conference	As specified in Department of Finance Purchasing Division Bid Sheet	10:00 A.M.
3.	Deadline for "Intent to Bid" Notification To State	Two (2) Business Days following Pre-bid Conference	5:00 P.M.
4.	Deadline for Submitting Questions after Pre-Bid Conference	Five (5) Business Days following Pre-bid Conference	5:00 P.M.
5.	Answers to Questions will be Mailed	Ten (10) Business Days following Pre-bid Conference	12:00 Noon
6.	Bid Submission Date	As specified in Department of Finance Purchasing Division Bid Sheet	5:00 P.M.
7.	Opening of Bid Responses	As specified in Department of Finance Purchasing Division Bid Sheet	10:00 A.M.
8.	Notice of Award (Estimated)	One (1) month following opening of Bid responses	
9.	Contractor Begins Work (Estimated)	Two (2) month following opening of Bid responses	
10.	AMMIS Operation Begins	October 1, 2011	

1.06 Inquiries

Unless otherwise noted, prospective Bidders may make written inquiries concerning this ITB to obtain clarification of requirements. Telephone or fax inquiries will not be accepted. No inquiries will be accepted after the deadline for questions as specified in the *Schedule of Activities*. Send all inquiries to:

Paul Brannan
MMIS Coordinator
Alabama Medicaid Agency
P. O. Box 5624
501 Dexter Avenue - Room 5032
Montgomery, Alabama 36103-5624

We encourage the use of e-mail.
E-Mail Address: paul.brannan@medicaid.alabama.gov

Bidders shall mark envelope /email subject line "ITB #10-X-2205737 - Inquiry".

Any attempt by a Bidder to contact any employee of the Alabama Medicaid Agency regarding this ITB prior to bid award, other than as specified in this ITB, shall be deemed to be a violation of bid requirements and shall result in the Vendor's bid being rejected.

Bidders who submit questions via mail shall submit their questions in electronic format on a CD/DVD (in Word 6.0 or higher format) to the address specified above. Bidders should not rely on verbal statements that alter any specifications or other terms or conditions of the ITB.

Questions regarding the State Purchasing Division bid process should be addressed to the Division of Purchasing by phoning or writing the following buyer:

Ray Bressler
State of Alabama
Department of Finance
Division of Purchasing
PO Box 302620
Montgomery, Alabama 36130-2620
Telephone: (334) 242-4670

1.07 Mandatory Pre-bid Conference

A mandatory Pre-Bid Conference will be held on the date and time specified in the *Schedule of Activities*, at the Division of Purchasing Auditorium in the RSA Union Building, Suite 192, 100 North Union Street, Montgomery, Alabama. Attendance at the pre-bid conference is mandatory for all Vendors who plan to submit bids. A Vendor's failure to attend the pre-bid conference will cause their bid to be rejected. Such topics as

organizational structure, Agency history, and current and planned program activities shall be addressed by Agency personnel.

The pre-bid conference is intended to be an interactive exchange of information. An opportunity will be given to ask questions to clarify any uncertainties which exist. Since impromptu questions shall be permitted and spontaneous answers may be provided, Bidders should clearly understand that oral answers given at the conference are not binding, but are good faith efforts to give correct useful information. No further questions will be permitted after the date specified in the *Schedule of Activities*. Final and binding answers to all questions whether submitted via mail, email or asked at the pre-bid conference will be distributed to all conference attendees on the date specified in the *Schedule of Activities*.

Answers to written questions received by the MMIS Coordinator before the pre-bid conference by the deadline specified in the *Schedule of Activities* shall be distributed at the pre-bid conference. Prospective Bidders will be given time to review the written questions and answers during the Mandatory Pre-bid conference. Prospective Bidders may email or mail their questions as specified above up to the deadline for all questions.

1.08 Agency Bid Opening Rights, Bid Questions and Contacts

The Agency reserves the right to reject any bids submitted in response to this ITB.

Subsequent to the opening of the sealed bids, discussions may be conducted by the Agency and the Division of Purchasing with Bidders for the purpose of clarification to assure full understanding of and responsiveness to the solicitation requirements. Bidders shall be accorded fair and equal treatment with respect to any opportunity for discussion. In conducting any such discussions, there shall be no disclosure of any information derived from bids submitted by competing Bidders.

Any questions regarding solicitation requirements for this ITB must be written and submitted by the designated due date and time specified in the *Procurement Timetable* to the Division of Purchasing Buyer at the address shown above. Questions will not be addressed over the telephone. Responses to Bidder's questions shall be made available to all Bidders attending the Mandatory Pre-Bid Conference on the date and time designated in the *Procurement Timetable*.

1.09 Intent to Bid

All Bidders planning to submit a bid must submit an "Intent to Bid Notification" letter by the deadline specified in the *Procurement Timetable*. Failure to timely submit an "Intent to Bid Notification" letter will result in the Bidder not meeting mandatory responsiveness requirements and the Bidder will not be sent answers to questions, amendments or other materials regarding this bid. The format for the "Intent to Bid Notification" letter can be found in *Section 7.02 - Appendix B – Attachment 3 – Intent to Bid Notification*.

Send correspondence to:

Paul Brannan
MMIS Coordinator
Alabama Medicaid Agency
P. O. Box 5624
501 Dexter Avenue - Room 5032
Montgomery, Alabama 36103-5624

Mark envelope/document "ITB #10-X-2205737 - Intent to Bid".

1.10 Bidder's Submission

Bids must be received on or before the deadline in the *Procurement Timetable*. Late proposals shall not be accepted. It is the responsibility of the Bidder to ensure that the proposal is received by the Department of Finance, Purchasing Division in accordance with the *Procurement Timetable*. The bid, packaged in accordance with the *Section 4 – Bidder Response Format*, shall be sent by mail to:

State of Alabama
Department of Finance
Division of Purchasing
PO Box 302620
Montgomery, Alabama 36130-2620
Attention: Ray Bressler

or delivered to:

State of Alabama
Division of Purchasing
RSA Union Building
100 North Union Street, Suite 192
Montgomery, Alabama 36104
Attention: Ray Bressler

The State of Alabama Invitation to Bid form must be signed in ink by the Bidder or other entity that is legally authorized to bind the Bidder to the bid. The Invitation to Bid form must also be notarized.

Bids not meeting these requirements shall not be accepted.

The Division of Purchasing desires and encourages that bids be submitted on recycled paper, printed on both sides. While the appearance of proposals and professional presentation is important, the use of non-recyclable or non-recycled glossy paper is discouraged.

1.11 Withdrawal of Proposals

Bids withdrawn by the Bidder prior to award shall result in forfeiture of the Bid Bond.

1.12 Addendum or Supplement to ITB

In the event that it becomes necessary to revise any part of this ITB before the mandatory pre-bid conference, an addendum shall be provided to each Vendor who received the original ITB. It is the Vendor's responsibility to inform the Division of Purchasing of its interest in the ITB if it has not received the ITB in a direct mailing from the Division of Purchasing. In the event that it becomes necessary to revise any part of this ITB after the mandatory pre-bid conference but before the deadline for submitting "Intent to Bid Notification" letters, an addendum shall be provided to each Vendor who registered at the pre-bid conference. In the event that it becomes necessary to revise any part of this ITB after the deadline for submitting the "Intent to Bid Notification" letter, an addendum shall be provided to each Vendor who attended the Mandatory Pre-Bid Conference and submitted an "Intent to Bid Notification" letter before the required deadline.

1.13 Oral Presentations and Systems Demonstration

The Agency reserves the right to request oral presentations during the Evaluation Phase. The purpose of the oral presentation is to allow for interchange between the Bidder, Agency staff and the Evaluation Committee. It shall be the Agency's option to determine the schedule and format for oral presentations/demonstrations. Bidders will be notified in advance of the time and location and selected items of any such presentations.

The oral presentations and demonstrations will provide an opportunity to 1) provide an overview of the merits of the Bid Proposal, 2) answer questions raised by evaluators in the course of reviewing the Bid Proposals, and 3) assist the Evaluation Committee in verifying the capabilities and functionality of the proposed system. The Evaluation Committee shall have the opportunity to ask for clarification of information in the proposal. No written supplementation of the bid will be permitted. Responsiveness will be determined on the written bid proposal.

During the oral presentations, Bidders shall not discuss the merits or qualifications of other Bidders. Failure to observe this bid requirement shall result in the bid being rejected as non-compliant.

The Agency may, at its discretion, establish such procedures and rules of conduct as it may deem appropriate, and may enforce such procedures and rules of conduct. Failure to observe these procedures and rules of conduct shall result in the bid being rejected as non-compliant.

1.14 Acceptance of ITB Terms

A bid submitted in response to this ITB shall constitute a binding bid response. The provisions of this ITB and all attachments constitute contractual terms and conditions. These provisions, as amended, shall supersede any contradictory or inconsistent language in the successful Bidder's response. A submission in response to this ITB acknowledges acceptance by the Bidder of all terms and conditions, including performance and compensation, as set forth in this ITB. The Bidder, by signing the bid sheet, certifies that it accepts all of the terms and conditions, including performance and compensation of this ITB in full, without reservations, limitations, assumptions, restrictions, caveats, or any other type of qualification. A response which fails to comply with this condition shall be disqualified as nonresponsive. Further, any amendment to this ITB shall be signed and returned with the bid or the bid shall not be considered.

All bids become the property of the State of Alabama, and may not be returned to the Bidder. Only bids which conform to the requirements of this solicitation shall be acceptable. The State reserves the right to reject any or all bids. There is no guarantee that a contract shall result from this solicitation. The State accepts no obligation for costs incurred by any Bidder in the preparation of a bid in response to this ITB.

1.15 Protested Solicitations and Awards

Any person who is aggrieved in connection with the solicitation or award of a contract may protest to the State of Alabama, Division of Purchasing Director. The protest shall be submitted in writing within the time period required by the State of Alabama, Division of Purchasing.

1.16 Confidential/Proprietary Information

Other than the bid prices, all documents and other materials pertaining to the bids shall be held confidential until issuance of award. After that time, pursuant to Code of Alabama (1975) Section 41-16-24, all original bids together with all documents pertaining to the award of contract will be retained and made a part of the permanent file or records and shall be open to public inspection at the Department of Finance, Division of Purchasing.

1.17 ITB Response Material Ownership

All material submitted regarding the ITB becomes the property of the State of Alabama. Bid responses may be reviewed by contacting the State of Alabama, Finance Department, Division of Purchasing after the notice of award letter has been issued by State Purchasing.

1.18 Proposal Prices

Bidder shall submit a firm and fixed price for the services described in the ITB. Bidder shall bid a price which reflects any business risk it perceives in the way the bid

specifications are stated. Bidder shall not anticipate nor rely on clarifications, discussions, redefinition, or further negotiations with the Agency after the contract award to adjust the price that is contained in its proposal for the work required by the ITB. Any efforts by a Bidder to limit, qualify, caveat, restrict or place conditions upon the price being bid shall be considered to be a violation of the firm and fixed price submission requirement and shall result in the bid being rejected as non-responsive.

1.19 Selection of Proposal

After review of the Evaluation Committee's recommendation for award, the Commissioner of Medicaid shall make the decision on award of contract. After selection is made, the Division of Purchasing shall issue a notice of award to the successful Bidder. Contract execution is contingent upon Centers for Medicare and Medicaid Services (CMS) approval of the award.

1.20 ITB Cancellation

The State reserves the right to cancel this Invitation to Bid at any time, without penalty.

1.21 State Ownership of Contract Products/Services

All products/services produced in response to the contracts resulting from this ITB, including the executed contracts, ITB, and any amendments thereto, shall be the sole property of the Agency. Vendor's response to the ITB, the Agency's written responses to prospective Bidders' questions, and Vendor's clarifications as requested by the Agency during the evaluation process shall become contractual obligations.

1.22 Incurring Costs

The State of Alabama is not liable for any cost incurred by Bidders prior to issuance of a legally executed contract.

1.23 Parent Company

If a Bidder is owned and controlled by a parent company, the main office address and parent company's tax identification number shall be provided in the bid response.

1.24 Certification of Independent Price Determination

1. By submission of this bid each Bidder certifies and in the case of a joint bid each party thereto certifies as to its own organization that in connection with this procurement:

    a. The prices in this bid have been arrived at independently, without consultation, communication, or agreement, for the purpose of restricting competition as to any material relating to such prices with any other Bidder or with any Competitor;

b. Unless otherwise required by law, the prices which have been quoted in this ITB have not been knowingly disclosed by the Bidder and shall not knowingly be disclosed by the Bidder, directly or indirectly, to any other Bidder or to any Competitor prior to opening; and

c. No attempt has been made or shall be made by the Bidder to induce any other person or firm to submit or not to submit a bid for the purpose of restricting competition.

2. Each person signing the bid form certifies that:

a. He/she is the person in the Bidder's organization responsible within that organization for the decision as to the prices being offered herein and that he/she has not participated, and shall not participate, in any action contrary to 1(a) through 1(c) above; or

b. He/she is not the person in the Bidder's organization for the decision as to the prices being offered herein but that he/she has been authorized in writing to act as agent for the person(s) responsible for such decision in certifying that such persons including said agents have not and shall not participate in any action contrary to 1(a) through 1(c) above.

1.25 Bid Guarantee

Each sealed bid shall be accompanied by a bid guarantee consisting of a bid bond issued by a company authorized to do business in the State of Alabama. The guarantee shall be payable to the State of Alabama in the amount of three hundred thousand ($300,000) dollars, as a guarantee of good faith and to ensure a firm bid for contracting purposes for nine (9) months after bid due date. Bid guarantees provided by unsuccessful Bidders shall be returned after ninety (90) calendar days from contract award. Letters of credit or cashier's checks are not acceptable.

1.26 Performance Bond

Please refer to *Section 6 – General Terms and Conditions*
Section 6.05.07 - Performance Bond.

1.27 Procurement Library

A Procurement Library has been established by the Agency in the Montgomery office for the use of all prospective Bidders in developing their bids. *Section 7.06 - Appendix F – Procurement Library Contents* provides a list of documents in the Procurement Library.

Use of the Procurement Library shall be scheduled in half day intervals, Monday through Friday, from date of ITB issuance through date of bid submission, from 8:30-11:30 a.m. and 1:00-4:30 p.m. Central Time. Scheduling shall be made by the ITB Project Officer,

Medicaid, (334) 242-5017. Prospective Bidders may not schedule more than four (4) consecutive half day intervals. Reproduction of materials shall be at the Bidder's expense. Bidders shall arrange for the use of a portable copier to reproduce materials not available in prepackaged form. Some of the documents provided in the Procurement Library are available on CD/DVD and/or the Agency WEB site http://www.medicaid.alabama.gov

1.28 Contract Timeframes

Please refer to *Section 6 – General Terms and Conditions – Section 6.01.05 – Term of Implementation Contract and Section 6.01.06 – Term of Operational Contract*.

1.29 Payment

The Agency will provide payment to the Vendor according to *Section 6 – General Terms and Conditions – Section 6.09 – Method of Payment and Invoicing*.

1.30 Public Opening of Bid

A public opening of the bid will be held as specified in the *Procurement Timetable*, at the Division of Purchasing, RSA Union Building, Montgomery, Alabama. A register of bids consisting of the names and addresses of Bidders will be prepared and made available for public inspection.

1.31 Bid Submission Requirements

Please refer to *Section 4 – Bidder Response Format*

1.32 Granting of Contracts

The contracts awarded under this ITB will be made to the lowest responsible and responsive Bidder as required by Section 41-16-27 (a), Code of Alabama (1975).

Specimen contracts are found in this ITB in *Section 7.02 - Appendix B – Attachment 1 – Implementation Contract and Attachment 2 – Operations Contract*. The Vendor reserves the right to add provisions consistent with the successful Bidder's offer and to negotiate with the successful Bidder other additions to or deletions from, and/or changes in the language in the contract, provided that no such addition, deletion or change in contract language shall alter the scope of work required and/or the evaluation criteria set forth herein. Additions to, deletions from and/or changes in language of the contracts shall not result in additional compensation over and above that bid by the successful Bidder for the scope of work specified in the ITB, the amendments thereto, the written answers to questions or any clarifications requested by the Bidder during the evaluation process.

Prior to finalization of award, the selected Bidder may be required to enter into discussions with the State to resolve any contractual differences before an award is made. These discussions must be finalized and all exceptions resolved within seven (7) working

days of notification of award; if not, the bid will be rejected and discussions initiated with the next lowest responsible and responsive Bidder.

1.33 Disclaimer

All statistical and fiscal information contained in the ITB and its exhibits, including amendments and modifications thereto, and all materials in the procurement library, reflect the best and most accurate information available to the Agency at the time of ITB preparation. No inaccuracies in such data shall constitute a basis for an increase in payments to the Vendor, a basis for delay in performance nor a basis for legal recovery of damages, either actual, consequential or punitive except to the extent that such inaccuracies are shown by clear and convincing evidence to be the result of intentional misrepresentation by the Agency.

1.34 ITB Purpose

The purpose of this Invitation to Bid (ITB) is to competitively procure Vendor services to enhance and operate the current Alabama Medicaid Management Information System (AMMIS) for the State of Alabama Medicaid Agency and to serve as fiscal agent on an annual operational contract. The Alabama Medicaid Management Information System (AMMIS) consists of all subsystems of the MMIS except the Recipient Subsystem.

The operational phase of the contract will include claims and encounter processing and other fiscal agent services as well as ongoing system change support. The Alabama MMIS must continue to meet or exceed user needs identified in *Section 3 – Requirements* of this ITB as well as additional requirements defined or clarified during initial Implementation Phase activities. The enhanced MMIS must continue to meet the revised functional definition of system requirements contained in Part 11 of the State Medicaid Manual (SMM) issued by CMS. The modified AMMIS must meet or exceed performance standards and expectations included in this ITB.

The MMIS must continue to:

- Ensure that each system and subsystem meets or exceeds Federal Certification and Performance Standards.
- Ensure that future changes in Alabama Medicaid Programs can be implemented accurately, efficiently and in a timely manner.
- Ensure increased flexibility in report definition so as to allow enhanced access to useful information that reflects the dynamics of the program.
- Provide enhanced management reporting.
- Provide system flexibility to make incorporate policy changes in a timely manner.

1.35 Bidders Qualifications

The successful Bidder shall have a minimum of ten (10) prior years experience in the design, development, implementation, and operations of large healthcare transaction systems and applicable regulatory certifications. The successful Bidder shall also have experience providing Fiscal Agent services in a health care claims processing operation.

1.36 Background Information

Medicaid was created in 1965 by Congress, under the provisions of Title XIX of the 1965 amendments to the Social Security Act. Medicaid started in Alabama in 1970 as a State Department of Public Health program. In 1977, the Alabama Medical Services Administration was made an independent state Agency. In 1981 it was renamed the Alabama Medicaid Agency. The Agency is responsible for assuring that Medicaid eligible Alabamians have the opportunity to request and receive Medicaid services by qualifying through an eligibility process. Providers of direct services are reimbursed for medical services received by Medicaid recipients. The Agency makes reimbursement for different services and functions using federal and state matching funds. The federal financial participation's (FFP) federal medical assistance percentage match (FMAP) for specific Medicaid cost can be up to 75 percent or higher with most other administrative costs receiving 50 percent federal funding. The remaining funding percentage is made up of State or other funding sources.

In fiscal Year (FY) 2006, the Agency paid $4,078,065,024 for health care services to Alabama citizens. Another $111,895,341 was expended to administer the program. (See Medicaid's 2006 Annual Report at; http://www.medicaid.alabama.gov/documents/Resources/4J-4_Annual_Reports/4J-Medicaid.AR2006a.pdf). This means that almost 98 percent of every Medicaid budget dollar goes toward purchasing services for recipients. Alabama's population grew from an estimated 4,642,736 in 2005 to an estimated 4,681,833 in 2006. The segment of the population eligible for Medicaid services has risen from 10.4 percent in FY 1990 to 21.1 percent in FY 2006.

During FY 2007, there were 932,521 persons eligible for Medicaid in at least one month of the year. The average number of persons eligible for Medicaid per month was 736,958. The monthly average is the more useful measure of Medicaid coverage because it takes into account the length of eligibility. Of the 988,678 persons eligible for Medicaid in FY 2007, about 79 percent actually received care for which Medicaid paid. These 736,958 persons are referred to as recipients. The remaining 195,563 persons incurred no medical expenses paid for by the Agency. Many of the individuals who had no medical expenses paid for by the Agency were partially eligible such as Qualified Medicare Beneficiaries (QMBs) only or Specified Low-income Medicare Beneficiaries (SLMBs).

STATEMENT OF WORK

This part of the ITB describes the work the Vendor will be expected to perform during the period of the DDI (Design, Development & Implementation) portion of the contract.

The implementation phase shall be structured to accommodate the winner of the contract. This statement of work is divided into two (2) sections: Operational Implementation and Enhancement Implementation.

- A non-incumbent Vendor will be given twelve (12) months from the signing of the contract or until October 1, 2011 whichever date occurs first to complete the Operational Implementation phase. The non-incumbent Vendor will be given an additional six (6) months from the operational implementation to complete the enhancements.
- An incumbent Vendor will be given six (6) months from the signing of the contract to complete the enhancements.

The Bidder must read all sections of the ITB to get a complete understanding of the requirements. Many requirements from the current contract have been modified to include performance measures. These performance measures are not considered enhancements. System modifications or specified additional personal are considered enhancements.

2.01 Introduction

The selected Vendor shall, upon contract signing, begin work on the Alabama Medicaid Management Information System (AMMIS). The completed system (operational system plus enhancements) will meet the functional requirements outlined in *Section 3 - Requirements*. The enhancements will be further defined as necessary by Agency staff during the requirements definition phase. The expected scope of work for the development of the enhancements is described in the *Enhancement Implementation Phase*.

Following the implementation of the AMMIS, the Vendor will continue to operate, maintain, and modify the system for the full contract term and perform Vendor responsibilities described in *Section 3 - Requirements*. The Agency encourages Vendors to propose the best technical solutions available to meet the needs of the Alabama Medicaid program implementing enhancements and to perform their Vendor responsibilities in a thoroughly professional and responsive manner.

The Agency requires Vendors to use structured design methodologies that focus on a Service Oriented Architecture (SOA). The Vendor's methodology shall support future Health Insurance Portability and Accountability Act (HIPAA) changes, and the continuing evolution of the Medicaid Information Technology Architecture (MITA) initiative.

The Alabama Medicaid Management Information System (AMMIS) consists of the subsystems specified in *Section 3 - Requirements*.

The *Operations Implementation Phase* only applies to a new vendor. The incumbent Vendor would not be required to perform this phase. The Vendor's scope of work during the Operations Implementation Phase has been further defined into six (6) separate tasks. The six (6) tasks included as the scope of work for the Operations Implementation Phase of the modified AMMIS are:

1. Operations Transition Contract Start-Up and Project Planning
2. Operations Transition Plan
3. Operations Transition Design
4. Operations Transition Construction
5. Operations Transition Testing
6. Operations Transition Implementation.

The Vendor's scope of work during the *Enhancement Implementation Phase* has been further defined into five (5) separate tasks. The five (5) tasks included as the scope of work for the Implementation Phase of the modified AMMIS are:

1. Enhancement Start-Up and Project Planning
2. Enhancement Requirements Definition
3. Enhancement Construction
4. Enhancement Testing
5. Enhancement Implementation.

If the Vendor's system development methodology supports different but equivalent tasks, the Vendor must cross-reference the task list as provided to their methodology. The Vendor must clearly define the objective, the entrance and the exit criteria for each phase in their methodology.

The Agency will closely monitor the timely and adequate performance of all Implementation Phase tasks. The Agency may use professional consulting services to assist Agency staff in managing all contract activities. The Vendor shall work with all consulting services selected by the Agency. The consulting services, with the Agency's approval, shall have access to all documents and meetings related to the project.

2.02 AMMIS Implementation Phase Objectives

The Agency has identified the following objectives for the scope of work to be performed during the Operations Implementation Phase and the Enhancement Implementation Phase:

- Ensure that the AMMIS is responsive to the current needs of the Agency and flexible enough to accommodate changing program directions.
- Maximize the ease of modifying the AMMIS, in terms of efficiency and expediency in response to Agency, State and federally required changes.
- Utilize automated design, development, and testing tools to the maximum extent possible to achieve cost and schedule efficiencies.
- Ensure the AMMIS incorporates the best use of technical solutions to provide service to Medicaid program providers.
- Ensure that the AMMIS is rigorously tested and properly installed prior to the start of operations or production implementation.
- Demonstrate that the AMMIS can fully communicate with the Agency and outside entities.
- Ensure each enhancement is fully tested prior to production implementation.
- Ensure that the AMMIS is complete, fully operational, and operates as the current AMMIS within twelve (12) months of contract signing or by October 1, 2011 whichever date occurs first.
- Update or create all documentation including requirements to reflect the current state of the AMMIS.
- Update the MITA State Self-assessment to reflect the current state of the AMMIS.
- Ensure that the AMMIS uses electronic data and automated processes whenever possible.
- Utilize n-tier architecture, Internet browser pages, thin clients, relational database structure and multiple security levels.

2.02.01 Information Systems Design and Development Requirements

This subsection presents general information systems requirements that the Vendor shall meet during all Implementation Phases.

2.02.01.01 Structured Design and Programming

All system components that are being developed as part of the enhancements to the AMMIS shall use SOA and MITA concepts.

2.02.01.02 Separate Development and Testing Environments

The proposed enterprise architecture shall provide for adequate configuration management, production (database and programs) control, versioning and audit capabilities to support the production and multiple test environments.

The proposed architecture for the Implementation Phase shall provide for separate development and multiple testing environments for all applications. It shall ensure that work being performed in the development environment is completely separate from any of the testing environments. The system environment shall provide access to data and files in the testing environment under Agency-approved limitations.

2.02.01.03 Hardware

The Vendor may propose any hardware platform that will support the current AMMIS and requirements set forth in this ITB. The current AMMIS is an n-tier design with Sun and Microsoft IIS servers. However, the proposed hardware platform shall be easily upgradeable and/or expandable if:

- It is discovered that the system has insufficient capacity to meet the performance expectations described in *Section 3 - Requirements*
- Changes made to the architecture as a result of the Requirements Definition or System Design Task activities require additional processing capacity, or
- Additional processing capacity is required to respond to changes to the Alabama Medicaid program during the Implementation and Operations Phases of the contract.

2.02.01.04 Software

The Vendor may utilize any applications programming language to enhance/modify the existing AMMIS. However, the current AMMIS is a transaction-based design on n-tier application framework and was constructed using Microsoft .NET.

Any proposed proprietary software and application languages shall be identified in the proposal and are subject to Agency approval. Clearly identified off-the-shelf software may be proposed for some capabilities and will be subject to Agency approval. The Agency encourages the use of web based thin client/interfaces. Any licenses required for modification and operation of proprietary software shall be the financial responsibility of the Vendor and shall be transferable to the Agency as defined in *Section 6 – General Terms and Conditions*.

The Vendor shall provide automated project management software for its use and the State's access via the web or the State's WAN. Such software shall require Agency approval and shall be licensed to the Alabama Medicaid Agency.

The proposed system software shall enable Agency technical staff and consulting staff to browse any libraries, test files and test environments regardless of the platforms being used for development. It shall also enable these Agency resources to access the same software development tools used by Vendor staff to assist in the development of test data and the evaluation of test results and system changes.

Any proposed commercial system software shall be compatible with, and accessible through, the State's existing software product suite (Microsoft Office).

The proposed software shall be easily migrated to a larger platform if the proposed platform is demonstrated to be insufficient to meet Alabama's performance expectations as described in *Section 3 - Requirements*.

2.02.01.05 Technical Specifications

The Vendor's equipment shall be compatible with the State's WAN and shall allow the transfer of files and electronic messages (e-mail) between Vendor and the Agency staff. The technical specifications for the State's WAN are contained in *Section 7.09 - Appendix I – State Technical Architecture*.

2.02.01.06 Security

The Vendor shall follow applicable technical standards for physical and data security during development of the AMMIS enhancements as prescribed by the Agency and CMS. These standards are defined in Federal Information Processing Standards (FIPS) Publications 31, 41, and 73, issued by the National Institute of Standards and Technology (NIST) and the HIPAA security regulations (45 CFR Part 142).

2.02.01.07 Documentation

Documentation, including all Operational and Enhancement Implementation Phase deliverables and resulting systems documentation (e.g., user documentation, operational procedures, provider manual, AMMIS systems documentation, detail design documents, MITA State Self Assessment) shall be provided in hard copy (if requested), stored in an electronic format and made available through a web based document repository tool. The document repository tool shall be organized to allow easy access to all documentation. The tool shall retain a minimum of ten (10) versions of each documentation, a date/time stamp and User ID for each version. The documentation shall be accessible to Medicaid users and approved contractors on the Agency intranet, the Agency & Vendor web portal, on-line, CD-ROM (per Agency request) and through the document repository tool operated by the current Vendor or other methods as approved by the Agency. The Vendor shall maintain or update all documentation to reflect the current state of the AMMIS enterprise (e.g. production, test, interfaces, and translator). Documentation shall include specific user friendly instruction on accessing and using each environment of the AMMIS (e.g. production, user acceptance test, model office test). Specific documentation standards will be defined during the Contract Start-Up and Project Planning Task.

2.02.02 Project Management Expectations

This subsection of the Implementation Phase Requirements presents the project management expectations that the Agency has identified for the Vendor to meet during the period from contract signing through production implementation of the requested enhancements. These expectations include minimum staffing requirements, location concerns, anticipated schedule for key milestones, reporting relationships and requirements, performance monitoring and Agency oversight.

2.02.02.01 Anticipated Project Schedule

The Implementation Phase will begin upon Agency and federal approval of the contract with the successful Bidder. The anticipated start date for the Implementation Phase is specified in the *Section 1.05.01 Procurement Timetable*. The Vendor will further define the schedule for the Implementation Phase, depending on the methodology proposed. The Vendor's response will use anticipated start date in the *Section 1.05.01 Procurement Timetable* as a start date for all project tasks or activities. All tasks that are identified in the proposal will be based on the number of days from the start of the contract. When the actual start date of the contract is determined, the Vendor shall replace the estimated start date with the actual start date and all tasks shall be adjusted accordingly. The following activities are required to have associated dates (or number of days from the start of the contract):

- Transition Project Start-up & Project planning
- Transition Plan

- Transition Design
- Transition Construction
- Transition Testing
- Operations Implementation
- Enhancement Project Start-up & Project Planning
- Enhancement Design
- Enhancement Construction
- Enhancement Testing
- Enhancement Implementation
- Project Closure

For non-incumbent Vendors, the AMMIS shall be operational within twelve (12) months of contract signing or by October 1, 2011 whichever date occurs first. The enhancements shall be complete within six (6) months of contract signing for incumbent Vendors or within six (6) months of operational implementation for non-incumbent Vendors. The AMMIS operations start date of October 1, 2011 is a critical date and will be subject to damages, as specified in *Section 6.11.02 Operational Start Date Damages* of this ITB.

The Vendor's schedule shall show completion of all tasks prior to the beginning of the user acceptance testing or parallel testing. AMMIS Operational Implementation task activities, such as the installation of equipment, system operations documentation, training of staff, providers and users, may overlap the other Operational Implementation Phase tasks, as necessary, to ensure a timely start of operations.

The Agency strongly recommends that the Vendor's proposed approach closely coordinates all activities so that activities are conducted concurrently with significant user involvement. The Agency encourages the Vendor to overlap activities where appropriate to proceed to system construction in a timely manner.

The Agency will actively monitor Vendor activities during the project by reviewing deliverables, participating in meetings, attending peer reviews, performing user acceptance testing and many other activities. Weekly status meetings will be required during the Implementation Phase and shall be attended by Agency project management staff, program users, contractors, and the Vendor’s Implementation Manager and designated technical staff.

Payment to the Vendor for Implementation Phase tasks shall be based on completion of the contract deliverables defined in *Section 6 – General Terms and Conditions*.

2.02.02.02 Reporting and Approvals

Standard Vendor requirements for reporting status and obtaining Agency approvals include the following:

- Report progress against the approved work-plan for each task through bi-weekly written status reports and at weekly progress review meetings with the Agency AMMIS Implementation Phase Project Manager

- Document weekly status meetings in writing, summarizing the key points covered, and provide a draft of this summary no later than 9:00 a.m. the second business day after the meeting

- Update the project work-plan and task schedule bi-weekly

- Deliver written status reports and updated work-plans/schedules by 9:00 a.m. one (1) business day before the status meeting

- Define templates for each deliverable. The Vendor shall prepare description of the contents for each section of the template to demonstrate an understanding of the purpose and content. The Vendor shall obtain approval from the Agency for the sample and contents of each deliverable before beginning work on the deliverable. When the base deliverable contents are defined by federal rules (e.g., State Medicaid Manual), those requirements should serve as the basis for the outline to be submitted for approval.

- Conduct group product reviews for all major milestone deliverables and any other product requested by the Agency. This review will occur as a meeting with all applicable Agency staff in attendance. The product will be submitted to the Agency five (5) working days before the meeting along with a request for the meeting. The deliverable or product will be reviewed and modified in a meeting with the desired result of the meeting being an approved product or deliverable. See *Section 2.02.02.07 Deliverables* for more information on product reviews.

- Submit products or documents that are not part of a group product review to the Agency along with quality review documents identifying the review criteria and the name of the reviewer. The Agency shall have ten (10) days to review and return comment on the product or document to the Vendor. The Vendor shall then have ten (10) days to respond to comments. Any product or document that is not approved after the first round of comments & responses will be part of a group product review.

- Obtain written approval from the Agency on each deliverable.

- Identify and document in writing any scope of work issues. Specify the basis upon which an issue is considered to be out of scope, including appropriate ITB references.

- Obtain prior written approval from the Agency before commencing work on changes to the scope of the ITB.

- Obtain written approval of any change to a requirement defined in *Section 3 - Requirements*. The approval process will include a re-write of the requirement. The original requirement and the re-write shall both be retained. Requirements stand as defined in the ITB unless the Vendor has written approval for a change.

- All meetings with Agency staff shall be scheduled through the designated Agency representative and the Vendor shall produce and distribute meeting minutes within 3 days of the meeting.

- The Vendor shall notify and include Agency designated staff in all implementation related meetings at least twenty-four (24) hours or as soon as scheduled if less than twenty-four (24) hours. If the Vendor does not give the Agency a twenty-four (24) hour notice, they must notify all of the designated staff by phone and e-mail.

2.02.02.03 Key Personnel Requirements

The Vendor shall designate the following key personnel during the Implementation Phase:

- Account Manager

- AMMIS Implementation Manager

The general responsibilities, minimum qualifications, and expected start date for these key personnel are summarized in *Section 7.08 Appendix H – Staffing Requirements*. All key personnel shall be employed full-time at the Vendor's Montgomery location from their start date throughout the Operational and Enhancement Implementation Phases.

The Account Manager and the AMMIS Implementation Manager must be employed by the Vendor. They are not permitted to serve in any other position, including service on the current contract.

Resumes for all other key personnel not identified in the proposal and for the systems modification team, shall be submitted for Agency approval no later than thirty (30) days prior to the required start date for the position. Personal interviews with these individuals may be required prior to the Agency's approval of start of work on the Alabama account at the Agency's option.

The Agency will designate an AMMIS Implementation Phase Project Manager and staff to work directly with the Vendor. The Agency will also provide access to other key personnel from the Agency, as available and needed, throughout the Implementation Phase. The Agency shall identify a point of contact (POC) to coordinate access to Agency personnel. Except as expressly agreed to by the AMMIS Implementation Phase Project Manager, all contact with Agency staff should be coordinated through the POC. The Agency may use consultant services to provide technical assistance in monitoring the implementation phases.

2.02.02.04 Location and Facility Requirements

The Vendor shall establish the development and operations sites in Montgomery, Alabama during the Implementation Phase. The project planning, AMMIS conversion, system testing, interfaces testing and user acceptance testing activities shall be performed within the city limits of Montgomery.

The Vendor shall provide adequate working space, conference space, and free parking at the local development site to accomplish all of the Implementation Phase tasks in an efficient and professional manner. Specifically, a large well-equipped conference room will be required to accommodate Agency users, consultant staff, and Vendor staff during meetings, training sessions, group product reviews, work sessions, test reviews, and other activities during the Implementation Phase.

The Vendor shall provide dedicated working space at the Vendor's local facility for up to five (5) Agency and consultant personnel. These personnel will be working on-site at the Vendor's facility approximately fifty percent (50%) to one hundred percent (100%) of full-time, depending on the project task. Minimum requirements for the State's work area are as follows:

- One (1) private office with locking doors, with furniture and equipment appropriate for manager-level activities: file cabinet; desk; desk chair; desk lamp; two (2) additional chairs; bookcase; white board; telephone; PC, data line; and connectivity to the Vendor's LAN, with gateway to the Agency's WAN.

- Four (4) partitioned work areas, each with furniture and equipment appropriate for professional staff: file cabinet, desk, desk chair, desk lamp, white board, telephone, PC's, data line, and WAN/LAN connection.

- One (1) conference room with space, table, and chairs for a minimum of twelve (12) people, a large white board, conference phone, data line, and WAN/LAN connection necessary to carry out project management and monitoring activities.

- One (1) fax machine with plain paper capability and automated to send or receive faxes unattended.

- Access to a laser printer and copy machine with sorting, collating, and automatic feed capabilities.

- A minimum of seven (7) free parking spaces reserved for the Agency.

All PC's provided for Agency staff must be replaced every three (3) years. These PC's must be equal to or superior to the most advanced PC's provided to Vendor staff. These PC's must have the standard software installed on Vendor PC's and be updated when the Vendor updates their software. Compliance with these minimum requirements is subject to review and approval by the Agency.

This space shall be made available and maintained exclusively for Agency use for the duration of the contract.

2.02.02.05 Agency Responsibilities

The general responsibilities of Agency personnel are stated below. Specific responsibilities may be included in other areas.

- Act as a liaison to the Vendor in dealing with the user community, external agencies, and other Agency Vendors.

- Provide documentation and/or clarification on Agency resources, organization, staff, policy, interfaces, business partners, anticipated changes or any other information to support the Vendor implementation phase.

- Perform overall monitoring and management overview of the project to ensure timely progress and satisfactory completion of all tasks and activities.

- Review and approve the proposed format and content of all task deliverables prior to the Vendor preparing deliverable drafts.

- Review Vendor deliverables, determine the approval status of the deliverable, participate in group product reviews, request revisions when necessary and/or provide written comments to the Vendor within ten (10) business days of formal submission.

- Monitor Vendor progress toward achievement of task milestones and to the Vendor's work-plan and schedule.
- Conduct weekly status meetings with the Vendor to review progress against the work-plan.
- Review bi-weekly written status reports and work-plan/task schedule updates.
- Monitor progress toward achievement of project milestones and work-plan key dates.
- Review and approve/deny proposed system scope or requirement changes.
- Participate in planning or review sessions for project, tasks and activities.
- Approve Vendor proposed reporting metrics throughout the project.
- Provide notice to the Vendor of inadequate performance, problems or discrepancies.
- Request, review, and approve plans for corrective action.

2.02.02.06 Vendor Responsibilities

The responsibilities of the Vendor are identified for each of the tasks within the Operations Implementation Phase (OIP) and the Enhancement Implementation Phase (EIP). In addition, the Vendor has overall responsibility for the timely and successful completion of each of the tasks. The Vendor is responsible for clearly specifying and requesting information from the Agency in a manner that does not delay any part of the schedule.

The Agency project team will review the Vendor's proposed approach to assuming overall system responsibilities and the specific responsibilities in each of the Implementation Phase tasks. The approach to coordinating the responsibilities of the Agency with those of the Vendor to ensure overall project success shall be adhered to.

If the contract is awarded to a new Vendor, the Agency expects the new Vendor and the incumbent Vendor to work together on transitioning the AMMIS. The new Vendor will be responsible for coordinating activities with the incumbent. Both Vendors are expected to be courteous, responsive and professional. The Agency or a selected representative shall be included in all meetings between the two Vendors.

2.02.02.07 Deliverables

Specific task deliverables will have a deliverable definition template proposed by the Vendor based on the project methodology to be used. The template must be submitted to the Agency for approval at least 10 days prior to the Vendor starting work on the deliverable. The format (or template) of all documents must be approved by the Agency. In many cases, one template will be used for multiple documents. The Vendor shall indicate this when the template is submitted for approval. The Vendor's deliverables and documentation, however, shall meet the requirements listed in Part 11 of the State Medicaid Manual and contain all the criteria identified for the deliverable. All deliverables defined in the Statement of Work shall meet Agency-approved standards and content requirements. The Agency will accept electronic copies of all deliverables unless otherwise requested. The master version of all documents will be retained in a Vendor maintained on-line document repository. The Agency has the option of requesting specific documents in the following media: paper (multiple copies), CD or DVD, on-line or e-mail attachment.

Each document will be reviewed by the Agency's AMMIS Project Team and will require formal approval from the Agency (e-mail will be accepted). All project deliverables and test results that impact claims payment shall have a Group Product Review. The Agency has the option of requesting three (3) types of reviews:

1. A Group Product Review – the Vendor’s staff shall attend a meeting (in person) with the Agency and walk-through the deliverable. The deliverable will be submitted to the Agency for review five (5) days prior to the walk-through. The Agency will ask questions and request changes during the walk-through. The deliverable may be approved at the conclusion of the walk-through, but the Agency shall have the option of requesting an additional five (5) days after all changes requested during the walk-through are completed. The Vendor shall have a staff member (other than the meeting facilitator) attend the meeting to take meeting minutes.

2. Remote Review (webinar) – The Vendors staff shall facilitate a meeting on the web and walk-through the deliverable. The Vendor shall have a staff member (other than the meeting facilitator) at the meeting site to take meeting minutes. The process will be the same as the Group Product Review except conducted over the web.

3. Individual Review – The Vendors staff shall submit a deliverable to the Agency point of contact for review. The Agency shall have ten (10) days to review the deliverable and submit comments in the Agency defined review format. The Vendor shall have an additional ten (10) days to respond to Agency comments. If the deliverable is not approved with the Vendors response, a Group Product Review will be required.

All documentation shall be produced in accordance with the Quality Assurance Plan found in *Section 7.15 Appendix O – 2011 Alabama Medicaid AMMIS Procurement Quality Assurance Plan*. The Agency may request a Group Product Review or remote review for any deliverable submitted for an individual review. This request must occur within 2 days of the deliverable submission.

2.02.02.08 Milestones

Project milestones are listed for each task in the implementation phase. Each milestone denotes a checkpoint toward the completion of the implementation phase. The dates for completion of project milestones will be finalized for purposes of performance standards and implementation checkpoints in the Agency-approved work-plan and schedule for the Implementation Phase. The Agency will place an emphasis on achievable, realistic dates for the completion of quality deliverables. Payment of major activities within the Implementation Phase shall be conditional upon successful completion of deliverables or milestones. Damages may be assessed for failure to meet key dates, as specified in *Section 3 – Requirements*.

The Vendor's status reporting shall provide information on progress toward meeting milestone dates. The status reports shall be produced throughout the project. The Agency will monitor each milestone completion date to ensure that the operations start date will be met. Failure to meet any milestone completion date will be viewed as a signal to the Agency that a key date has not or will not be met. Damages may be assessed for failure to meet a milestone or the operations start date, as specified in *Section 3 – Requirements*.

2.02.03 Vendor Commitment to Quality Assurance/Quality Management

The Vendor selected will perform an essential role in Alabama Medicaid program administration. To maintain continuous focus on the importance of delivery of quality systems and services, the Vendor shall plan, implement, rigorously endorse, and constantly improve a quality assurance program.

The Agency does not seek a textbook approach to quality management. Instead, the Agency seeks Vendor endorsement of the fundamental importance of quality imbedded in a living plan to introduce, promote, reinforce, and acknowledge quality in all Vendor activities.

A quality assurance/quality management (QA/QM) plan is to be developed as part of the proposal and refined early in the Implementation Phase to address the needs and specific opportunities for quality improvement throughout the contract period. The QA/QM plan should reflect the bidder's experience and resolve toward quality in systems design, testing, and implementation; process design and staff training; performance standards development and measurement; and customer satisfaction measurement and analysis. As

part of its approach to quality management, the Vendor shall have a full time dedicated QA Manager to develop, support, and report progress against Agency approved quality metrics or software measurement criteria. This will allow both the Vendor and the Agency to assess the progress of the Operations Implementation Phase and/or Enhancement Implementation Phase. The QA Manager shall have primary responsibility for both quality assurance (i.e. quality processes are being consistently followed in all development stages) and quality control (i.e. all deliverables meet or exceed established quality standards). As part of the Quality Management Plan, the QA Manager shall define the Vendor review criteria for each deliverable and submit the criteria for Agency approval.

As part of the Vendor's commitment to quality, the Agency requires that key Vendor staff involved in the Implementation Phase will remain part of the Vendor's Alabama team until systems acceptance is completed. The Agency shall also require the Vendor to submit a QA checklist with each deliverable that indicates the criteria used to perform the quality review. The checklist shall contain the names of all parties involved in the review. Please see *Section 7.15 Appendix O – 2011 Alabama Medicaid AMMIS Procurement Quality Assurance Plan*.

2.03 Operations Implementation Phase (OIP) - Statement of Work

The six (6) tasks defined for the scope of work included under the Operations Implementation Phase include:

1. OIP Contract Start-Up and Project Planning
2. OIP Transition Plan
3. OIP Transition Design
4. OIP Construction
5. OIP Testing
6. OIP Implementation.

The Vendor shall define entrance and exit criteria for each phase. The Agency recognizes that the Vendor's system development methodology may not match these tasks as defined. Where Vendor definitions of tasks differ, a cross-reference with entrance and exit criteria of the Vendor's tasks to the ITB listing is required.

The objectives for each task have been identified and responsibilities to be fulfilled are outlined under each task below. Deliverables and required contents are defined, although the Agency recognizes that Vendor proposed design methodologies and development tools may result in different products at different project phases and may include unique naming conventions. Initial milestones for each task are listed to ensure that adequate progress can be measured. These milestones must be cross-referenced to the identified products.

Task-level descriptions of the scope of work are presented in the following subsections.

2.03.01 OIP Contract Start-Up and Project Planning Task

The objectives of the OIP Contract Start-Up and Project Planning Task are to:

- Finalize the work-plan and schedule
  - Update to reflect the actual contract start date
  - Update to reflect joint detailed planning with the Agency
  - Update to reflect the availability of Agency resources
  - Update to reflect all tasks and subtasks, along with the completion date for each
  - Conduct a Vendor quality review of the plan before submission to the Agency

- Define Deliverable templates
  - Identify templates for start-up phase
  - Discuss, refine, and finalize contents for Vendor deliverables
  - Identify criteria for Agency Approval

- Define quality and reporting metrics
  - Develop proposed metrics and metric gathering process
  - Present proposed metrics and gathering process for Agency approval
  - Implement Agency approved metrics and processes

- Develop the Detailed Implementation Schedule (DIS)
  - Define the DIS based on Agency approved work-plan and schedule
  - Define the cost allocation data
  - Define the resource availability and usage
  - Maintain the DIS throughout the Implementation Phase
  - Provide work-plans and schedules bi-weekly or when requested

- Secure and prepare both temporary and permanent facility space
  - Establish a Vendor facility in Montgomery, Alabama city limits within the first thirty (30) days of the start of the contract.
  - Establish secured off-site access for a minimum of twenty-five (25) Agency staff or contractors.
  - Ensure the temporary facility is of a sufficient size and structure to support Vendor and Agency needs until the permanent facility within the Montgomery, Alabama city limits is complete. This initial facility and the permanent facility may be the same.
  - Provide complete Agency offices, partitioned work areas, and conference room, as described in *Location and Facility Requirements*, within ninety (90) days of the start of the contract.
  - Establish Vendor Facility security

- Acquire hardware within two (2) months of contract start date
  - Install at the Vendor's facility and the Agency offices as appropriate
  - Provide full connectivity between the Vendor site and the Agency.
  - Supply all hardware as described in *Hardware* and *Section 7.09 Appendix I – State Technical Architecture for 2011*

- Define interfaces and working relationships between Vendor and Agency staff
  - Define approach and protocols
  - Present approach and protocols for Agency approval
  - Provide Agency orientation training

- Define software
  - Develop software standards
  - Present software standards to the Agency for approval
  - Define tools to be used

  - Present tools for Agency approval
  - Develop training schedule for Agency staff on Vendor tools
  - Submit training schedule to the Agency for approval
  - Conduct training for Agency staff on Vendor tools

- Establish Development Environment
  - Verify hardware and software installs
  - Establish connectivity and communications

- Establish Correspondence Tracking Process
  - Define the correspondence tracking process
  - Present the correspondence tracking process to the Agency for approval
  - Conduct training for Agency staff
  - Track all correspondence initiated by either the Agency or the Vendor

- Establish an issue tracking process and issue tracking software
  - Define the issue tracking process
  - Present the issue tracking process and software for Agency approval
  - Conduct training for Agency staff
  - Implement issue tracking process

- Initiate project management control and reporting procedures
  - Define control and reporting procedures
  - Present control and reporting procedure for Agency approval
  - Implement control and reporting processes

- Begin initial planning and site development for Vendor operations support.

- Conduct group reviews of all deliverables from this phase.

Project planning during this task includes detailed discussion of the overall implementation work-plan and finalization of the detailed work-plan for all tasks related to the Operations Implementation Phase of the project. Planning Task activities will include briefings, presentations, and training in the proposed system development life cycle methodology and any software tools the Vendor proposes. The Agency reserves the right to deny the use of any software it feels will negatively impact the project. Vendor-proposed deliverables/products for the Implementation Phase will also be reviewed, discussed, and finalized during this task.

The Agency encourages the Vendor to use software tools for project tasks and documentation. Any Agency approved automated tool set may be used to develop and maintain an integrated data dictionary, and panel and report layouts. The selected approach shall incorporate significant and continuous user involvement.

The Project Planning Task will result in a Final work-plan and Schedule reflecting the detailed work breakdown, staffing, deliverables, and schedule for all Implementation Phase activities.

2.03.01.01 OIP Project Start-up Task Deliverables

The deliverables defined below are due within twelve (12) weeks after the signing of the contract.

1. Final work-plan and Schedule - The Final work-plan and Schedule shall incorporate all Agency and Vendor tasks and activities and provide a detailed plan describing plans and contingencies to ensure an on-time, on-budget implementation. The Final work-plan and Schedule will be used by both the Agency and Vendor to monitor and manage the system implementation effort. The Vendor will work jointly with the Agency to review, revise, and finalize the work-plan. The Vendor will be responsible for making all revisions to the work-plan.

   The Final work-plan and Schedule shall include: an updated approved project schedule, work-plan, project objectives and scope, description of the project and deliverables, project assumptions, system life cycle description, listing of tools required, estimating assumptions, project milestones, project closure activity descriptions, project organization and staffing (including a staff loading chart for each task and for the entire phase), project interfaces, and project reporting approach. It shall address all milestones defined in this ITB with an expected date that the milestone will be met. A Gantt and a PERT chart showing all tasks, dependencies, and a critical path analysis shall be provided.

   The Final work-plan and Schedule submitted during this task will be presented at its most finite level of detail for the OIP & EIP Tasks. The work-plan must be organized by the tasks specified in this section and the system functions described in *Section 3 - Requirements*. It must also address all deliverables and milestones defined in this ITB with an expected date that the milestones will be met.

   The Final work-plan and Schedule shall be developed using an automated project management software tool. The tool and schedule supplied by the Vendor shall be the same tool and schedule the Vendor uses for internal project management. The Vendor shall provide an electronic copy of work-plan files and ten (10) copies or licenses of the project management software for Agency use. The Agency would prefer to use the tool used internally by the Vendor, if it meets all other requirements.

The Final work-plan and Schedule once approved will be base-lined. Any deviations of +/- seven percent (7%) will require submission and Agency approval of a Corrective Action Plan (CAP).

2. Detailed Implementation Schedule (DIS) - The DIS will be used by the Agency to monitor and manage the system implementation effort. In the DIS, the Vendor will provide an updated approved work schedule, work-plan, description of project deliverables, project resource requirements, and project management, approach to project interfaces, project reporting procedures, and updates to project cost and cost allocations. The DIS will be a dynamic document that must be maintained throughout the Implementation Phase. Updated work-plans and schedules must be provided to the Agency bi-weekly or as requested by the Agency.

3. Project Organization and Staffing Plan – this will identify the project team members, define the organizational reporting structure and project staffing requirements.

4. Project Charter - a 1-2 page summary of the project.

5. Project Kick-off Meeting – a meeting to introduce everyone and generate enthusiasm for the project. The meeting will consist of a brief overview of the project and a definition of roles.

6. Risk Management Plan – an analysis of likely risks with both high and low impact, as well as mitigation strategies to help the project avoid being derailed should common problems arise.

7. Communication Plan – the communication standards between the Vendor and the Agency. This will include the approach, the interfaces, working relationships and protocols.

8. Quality Management Plan – the methods that will be used to ensure quality throughout the project.

9. Issue Management Plan – the tools and methods that will be used to identify, track and resolve issues throughout the project.

10. Deliverable Definitions – templates and descriptions for each deliverable document.

11. Project Management Bi-weekly Status Reports – status reports to be created bi-weekly throughout the project.

12. Facility Security Plan – security measures for the temporary and permanent Vendor facility.

13. Project Orientation – this will identify Agency/Vendor interfaces and working relationships. It will also introduce the Agency to the Vendors approach to the project and train (or schedule the training for) the Agency on the use of Vendor tools.

2.03.01.02 OIP Project Start-up Milestones

The project start up milestones consists of the project deliverables defined for this phase and the following tasks:

- Deliverable templates for deliverables from this phase
- Project Management Bi-weekly Status Reports
- Vendor Tool Training schedule
- Completion of Agency work space at the Vendor's facility
- Establishment of the gateway to the State's WAN and current Vendor.

2.03.02 OIP Transition Plan

During this task, the Vendor will define their approach or high-level plan to transition the AMMIS from the current Vendor to the new Vendor. This Transition Plan will provide a high level overview of the process focusing on any changes that will occur with the transition. The Vendor shall also provide documents that contain the details of any changes including the reason for the change. Any change will require Agency approval.

2.03.02.01 OIP Transition Plan Task Deliverables

The OIP Transition Plan Task Deliverables will consist of:

1. Transition Plan – This plan will contain a high level overview of the new enterprise infrastructure and the process the Vendor will follow during the Operations Implementation phase. This plan shall be all inclusive, but it may point to the other transition plans for more specific information.

2. System Interface Transition Plan – This plan will contain the Vendor's approach to transitioning all internal and external system interfaces from the current Vendor.

3. Master Test Plan – This plan will define the Vendor's approach to testing, any tools that will be used and explain how the identified testing will work together to thoroughly test the AMMIS. The plan must include, but not be limited to the following information for each phase of testing:

    - The testing phase objective.
    - Testing phase entrance and exit criteria.
    - Testing phase reporting metrics.

4. Issue tracking process – this document shall define in detail the tool and process for identifying, tracking and approving the resolution of an issue. The Agency and the Vendor shall use the same tool and process.

5. Requirements Traceability Matrix (RTM) – this matrix will track each requirement from the ITB through all phases of the project (e.g. design, construction, testing, and implementation). The RTM will be bi-directional which will allow a requirement to be traced from the first phases to the last phases AND from the last phases to the first phases.

6. Ancillary Transition Plan – This plan will contain the vendors approach to transitioning all ancillary systems such as, but not limited to:

    - Provider Electronic Solutions (free software given to providers)
    - Translator
    - Automated Voice Recognition System (AVRS)
    - WEB
    - Long Term Care Notification Software
    - CROCS (Comprehensive Recipient On-line Collection System)

2.03.02.02 OIP Transition Plan Milestones

The Transition Plan milestones consist of the project deliverables defined for this phase and the following tasks:

- Deliverable templates for deliverables from this phase
- Project Management Bi-weekly Status Reports

- Agency training on Vendor tools
- Implementation of the issue tracking process
- Implementation of the quality management process

2.03.03 OIP Transition Design

The objectives of the Transition Design Task are to identify, plan and document all changes required to transition operations to the new Vendor. This phase will provide the detail information for the plans defined in the OIP Transition Plan task.

2.03.03.01 OIP Transition Design Task Deliverables

The OIP Transition Design Task Deliverables will consist of:

1. System Interface Document – this document(s) will identify the details for transitioning all system interfaces. It shall contain information such as but not limited to:
   - Identify interfaces
   - Identify Agency and business partner contacts
   - Identify interface frequency
   - Identify interface protocol
2. Data Conversion Document – this document(s) will identify the details for transitioning all data. This document will also identify any data clean-up required, and the Vendor process for cleaning the data. Agency approval will be required for any changes to the data. The Vendor shall be required to perform a minimum of four (4) mock data conversions. The results of the mock conversion shall be presented to the Agency for review. The Vendor shall make corrections or perform clean-up on the data as requested by the Agency.
3. Software Conversion Documents – this document(s) will identify the details for transitioning all system software including but not limited to inventories and libraries.

4. Configuration Management Plan – this document(s) will identify the details for maintaining the software between the current AMMIS and the new AMMIS.

5. System Back-up and Storage Plan – this document(s) will identify the details for transitioning local and off-site data backups and storage.

6. Call Center Documents – this document(s) will identify the details for transitioning the call centers. The Vendor shall create a document for each call center or create one document with sections for each call center. This will enable the Agency functional areas to focus on the document or section for their business area.
7. Support and Operations Documents – this document(s) will identify the details for transitioning all support and operations tasks.

8. UAT Training Plan – the Vendor's plan for training the Agency in UAT testing. This includes the Vendor's process and test tools.

9. Summary of Transition Changes – this document will be a summary of all changes from the current way of doing business to the new vendor's way of doing business. This document will be used to identify all training requirements for the new AMMIS. The Vendor shall schedule one or more meetings to walk the Agency through each change. The Changes will be subject to Agency approval. All areas should be addressed, but there shall be specific plans or sections to address the following areas:

    - Technical
    - Software (including configuration management)
    - Internal and external interfaces
    - Data content and format
    - Data Warehouse or DSS (Decision Support System)
    - Recipient Call Center
    - Provider Call Center
    - Electronic Claims Management (ECM) Call Center
    - Provider Enrollment
    - Vendor Support

- Operational Support
- Training (internal and external)

2.03.03.02 OIP Transition Design Milestones

The OIP Transition Design milestones consist of the project deliverables defined for this phase and the following tasks:

- Deliverable templates for deliverables from this phase
- Project Management Bi-weekly Status Reports
- RTM with updates from the Design Phase
- Vendor/Agency meeting(s) on the summary of transition changes.

2.03.04 OIP Transition Construction Task

The objectives of the OIP Transition Construction Task are to follow the information from the detail documents created in the OIP Transition Design tasks to make the changes required to transition the old AMMIS to the new Vendor. This phase will construct and test the new Vendor's AMMIS. The phase shall include but not be limited to:

- Develop, on the Vendor's hardware, the AMMIS
- Test all system process such as:
  - Inquiry
  - Update
  - User interfaces
  - Internal and external interfaces
- Perform unit and subsystem testing to ensure that the modified AMMIS will appropriately adjudicate all Medicaid claims, make all types of updates, and produce required reports and other outputs.
- Perform unit and subsystem testing on all internal and external interfaces to ensure that the AMMIS will process appropriately.

- Perform peripheral test such as but not limited to: Automated Voice Response System (AVRS), provider electronic solution software, long term care notification software, the translator, the web applications and Electronic Claims Management (ECM) automated claims submissions to ensure that the AMMIS will appropriately answer inquiries and adjudicate all Medicaid claims.

- Demonstrate, through detailed and subsystem testing, that the Vendor is ready to begin integrated system testing of the modified AMMIS.

The Agency will closely monitor Vendor activity during the OIP System Construction and Testing Task through the use of structured walkthroughs. The purpose of the walkthroughs will be to demonstrate that completed application programs will perform as desired by the Agency. The Vendor will be required to demonstrate to the Agency, in these walkthroughs, test results for all components of the AMMIS. During the walkthroughs, the Agency may identify additional documentation, further test cases or situations to be demonstrated by the Vendor in order to ensure that each functional area is adequately tested. Walkthroughs will be scheduled weekly throughout the Construction and Testing Task and a schedule will be provided to Agency personnel. The Agency will select the walkthroughs to attend.

2.03.04.01 OIP Transition Construction Deliverables

The deliverables of the OIP Transition Construction Task are:

1. Peer Reviews and Walk-through – the vendor shall conduct a peer review or walk-through of completed activities.

2. Unit and Subsystem Test Results – documented unit and subsystem test results to ensure that activities function correctly on Vendor hardware. These shall be presented or provided at Agency request.

3. Updated Transition Documents – update all documents with changes identified during the construction and testing phase.

4. OIP Implementation Plan – documented step by step process that will move the Vendor from system testing to production processing and support. The Agency will look favorably on a plan that makes the move in multiple phases. The plan shall include but not be limited to:

    - Define a detailed schedule of events

    - Identify plans and schedules for designing, ordering, and distributing all required AMMIS forms

- Identify plans, schedules, software, and procedures for implementing ECM and for updating/replacing existing PES software at all provider-specific PC stations

- Identify cutover procedures and dates for submittal of claims on EMC and hard copy

- Document resolution of inventory issues (e.g., suspense, claims on hand, provider enrollments) and associated dates

- Identify procedures and dates for provider enrollment and/or recertification, if required

- Identify the processes to accommodate provider updates, recipient data changes, reference changes, and prior authorizations after final conversion, but before implementation.

5. Draft Manuals and documentation – a draft version of all user, provider and system documentation shall be provided for Agency review. The Vendor may apply the OIP changes to the current manuals and documentation. The master version of all manuals is currently maintained on-line in a web based document repository. All manuals submitted for Agency approval must have changes clearly identified. The manuals and documentation shall be available on the intranet, the web, CD\DVD or in paper format as requested by the Agency. The documents shall be formatted in a manner that facilitates changes such as the use of track changes and versioning. All manuals and documentation shall be written in a manner that is understandable by business or non-technical staff. All manuals shall use a common nomenclature. The manuals shall include but not be limited to:

   - System Documentation - The Vendor is responsible for providing the Agency with a complete copy of the System Documentation within thirty (30) days following the Agency acceptance of the AMMIS. The documentation shall include but not be limited to:

     - A narrative of the AMMIS.

     - Data flow diagrams showing data stores and flows.

     - A description and flow charts showing the flow of major processes and data in each of the subsystems and across subsystems.

     - A description of the operating environment by general overview and by detailed description of each work unit, the flow of data, the interaction between work units, etc.

  - Documentation for each subsystem/functional area.
  - Listings of edits and audits applied to each input item, including detailed edit/audit logic, claim and provider types affected, edit/audit disposition, suspense and override data, and corresponding error messages.
  - Operations run documentation with schedules and dependencies which shall support Agency monitoring activities on an ongoing basis
  - Detailed pricing logic for all claims processed by the system
  - Lists, by identifying name, of all files, inputs, and outputs with cross-references to the programs in which they are used.

- A Tables manual shall be included in the Systems Documentation. It shall include for each subsystem/functional area but not be limited to:
  - A listing of table-driven or key elements, their values, and a written description of the element
  - Cross-reference listings or matrices of related elements or values showing allowable relationships or exclusions (e.g., provider type/provider category of service cross-reference)
  - A table of contents by table and element

- A data elements dictionary shall be included in the Systems Documentation.

- Hardware configuration diagram showing the relationship between all Information Systems and communication equipment necessary to operate the AMMIS, including, but not limited to, local area networks, ECM support networks, control units, remote job entry devices, data storage and transmission devices, printers, computers, PCs, and data entry devices.

- AMMIS Operating Procedures - The AMMIS Operating Procedures document defines the relationships and responsibilities of the Vendor and Agency personnel for AMMIS operations. It includes the manual procedures required to support the Alabama Medicaid program.

- Updated Provider Manual - The AMMIS Provider Manual will be used by the provider and/or vendor community to submit claims in the proper format for adjudication and to obtain information regarding billing, reimbursement, and program policies and procedures. The manual includes a chapter specific to each Agency-defined provider type.

- AMMIS User Documentation - The Vendor must update user documentation for each subsystem or functional area. User documentation

will be distributed (either in whole or in part, as appropriate) to all Vendor and Agency users, as needed or requested. During the Operations Phase, updates to user documentation must be presented with test results for Agency approval. The Vendor will be responsible for the production and distribution of all user documentation updates.

6. Training Plan – the Vendor shall submit for Agency approval a training plan that includes Agency staff, providers and other training identified by the Vendor or Agency.

- Agency Training Plan - The Agency Training Plan details all the activities leading up to, and including, the training of Agency user staff, at all levels and in all Agency locations, in the proper use of the AMMIS. Approximately three hundred (300) users in Montgomery will require training. Training for other Agency and District Office staff may take place regionally, as approved by the Agency. At a minimum, the training plan shall include:
  - An outline/agenda of each training session
  - A description of training materials
  - A description of training facilities
  - A training schedule
  - Plans for remedial training
  - Training Evaluation Criteria
  - A methodology to ensure continued training during the Operations Phase for new staff or staff changing positions
- Provider Training Plan - The Provider Training Plan details all the activities leading up to, and including, the training of all provider types in proper billing procedures, use of claim correction forms, understanding of remittance advices, program policy, etc. At a minimum, the Provider Training Plan shall include:
  - A description of training materials
  - Examples of training materials
  - A training schedule for all provider types, by provider type
  - Locations for training
  - Training Evaluation Criteria

- Plans for remedial training and ongoing training during operations

- Vendor Staff Training Plan - The Vendor Staff Training Plan details all the activities that must be accomplished for the training of Vendor claims suspense reviewers and customer communications staff in relevant knowledge of the Agency programs and the AMMIS before operations begin. At a minimum, the training plan shall include:
  - An outline/agenda of each training session
  - A description of training materials
  - Examples of training materials
  - A training schedule for all provider types, by provider type
  - Training Evaluation Criteria
  - Plans for remedial training and ongoing training during operations

7. Mock data conversion – conduct mock data conversions and present the Agency conversion metrics and reports for review. The Vendor shall be required to perform a minimum of four (4) mock data conversions. The results of the mock conversion shall be presented to the Agency for review. The Vendor shall make corrections or perform clean-up on the data as requested by the Agency.

8. UAT Training – conduct training for Agency UAT testers. This includes training on any processes or test tools used by the Vendor.

9. Disaster Recovery/Business Continuity plan (DR/BCP) – The DR/BCP plan will contain the Vendor's plan to ensure the continued operation of the Agency in the event of a disaster. The Vendor shall present the DR/BCP plan in a group review.

10. Test Plans - present the following plans in a walk-through. The Agency shall have five (5) days before the walk-through to review each plan. The Agency shall have an additional five (5) days after the walk-through to review the details of the plan. The Vendor shall make changes or additions as requested by the Agency. The plans include but are not limited to:

    - Integrated System Test Plan - (end-to-end testing) including test scenarios, cases and script
    - Parallel Test Plan – including the methodology to identify and verify the data processed through the parallel test system

- User Acceptance Test Plan – including the setup and support of Agency UAT test efforts.
- Stress Testing Plan – including the methodology for simulating three hundred (300) concurrent users across all subsystems and all electronic transactions.
- Regression Testing Plan – including the methodology to determine when regression testing should occur.

2.03.04.02 OIP Transition Construction Milestones

The Construction Plan milestones consist of the project deliverables defined for this phase and the following tasks:

- Deliverable templates for deliverables from this phase
- Project Management Bi-weekly Status Reports
- RTM with updates from the Construction Phase
- Agency approval of the results from the Mock Data Conversion
- A Vendor certification in writing that the AMMIS is ready for System Integration, Parallel, Stress, Regression and User Acceptance Testing.

2.03.05 OIP Transition Testing Tasks

The objectives of the OIP Testing Task are to fully test the new AMMIS. All phases of testing shall use data converted from the current AMMIS. The test case results must include updated documentation with changes tracked or a statement that no documentation update was necessary before receiving Agency approval. The testing phase shall include integrated system testing (end-to-end testing), parallel testing, stress testing, User Acceptance Testing (UAT) and regression testing.

2.03.05.01 OIP Transition Testing Deliverables

1. System Test Results – The Vendor shall perform system testing which demonstrates the AMMIS is fully functional. The System testing will: identify data entered into the system, follow the data through processing and

demonstrate the data is included in output reports and processes – otherwise known as end-to-end testing. The test results for all functional areas shall be presented to the Agency for approval. The Vendor shall execute additional test or retest as requested by the Agency.

2. Parallel Test Results – The Vendor shall perform a minimum of four (4) weeks of parallel testing. This testing shall mimic the production processing which includes loading the required history data. All inputs to the current AMMIS shall be used as input to the new Vendor's AMMIS. The new Vendor shall demonstrate that the new AMMIS functions as the current AMMIS. Any differences in processing shall be investigated, documented and presented to the Agency for approval. The parallel testing shall use production data and include two (2) financial check writes (one (1) must be a three (3) week check write) , processing for one month end in each functional area and one (1) true or simulated quarter-end. The test results for all functional areas shall be presented to the Agency for approval. The Vendor shall execute additional test or retest as requested by the Agency.

3. User Acceptance Testing – The Vendor shall present a fully functional AMMIS (i.e. all systems and parallel test have completed and approved by the Agency) for User Acceptance Testing. UAT shall be conducted by the Agency. The Vendor shall provide a tool which the Agency will use to define, track and report UAT metrics. The Vendor shall also support the Agency in the UAT environment and testing. The support shall include, but not be limited to environment setup, test setup, data loads, data manipulation, general test and tool support and issue resolution.

4. Regression Testing – The Vendor shall conduct regression testing throughout all testing phases. The Vendor must include applicable regression test results whenever system modifications are made to areas to which Agency approval has been given regardless of phase.

5. Stress Testing – The Vendor shall conduct stress testing on the AMMIS and all ancillary systems. The test results shall be presented to the Agency for approval.

6. Updated Implementation Plan – The Vendor shall present an updated (with changes tracked) implementation plan forty-five (45) calendar days before the actual go live date. The updated implementation plan shall contain all lessons learned and changes identified in the OIP testing phase. The Agency shall have ten (10) days to review the plan and request changes or additions.

7. Updated Manuals and Documentation - an updated version of all user, provider and system documentation (with changes tracked) that contains changes identified during testing. The Vendor shall submit these updates to the Agency for approval.

8. Updated DR/BCP – an updated version of the DR/BCP that contains changes identified during the testing phases. The Vendor shall submit these updates to the Agency for approval.

2.03.05.02 OIP Testing Milestones

The Transition Testing milestones consist of the project deliverables defined for this phase and the following tasks:

- Deliverable templates for deliverables from this phase
- Project Management Bi-weekly Status Reports
- RTM with updates from the Testing Phase
- A fully functional AMMIS

2.03.06 OIP Operations Implementation Task

During the OIP Implementation Task, the Vendor shall recruit and train operations staff, conduct provider and Agency staff training, and prepare for the start of operations for the Vendor's new AMMIS. It is anticipated that the activities for this task will run concurrently with the activities in other tasks defined for the OIP. The Vendor will receive and be responsible for processing claims as stated in *Section 3 - Requirements*. Please note that this is the only operations task that will run concurrently with the enhancement implementation tasks.

2.03.06.01 OIP Operations Implementation Deliverables

1. Develop and submit to the Agency for approval the final version of all deliverables.
2. Provide orientation and training for all Agency personnel on Vendor organization, Vendor functional responsibilities, and AMMIS operations.
3. Ensure the AMMIS will have the most current versions of software and data available.
4. Conduct final AMMIS file conversion, review results, and submit metrics to the Agency for approval.
5. Prepare a draft notice to providers, with Agency approval, in which AMMIS transition activities are identified, including pertinent information regarding the new contract, addresses, telephone numbers, training schedules, cutoff dates for claim submissions and enrollment changes, and all other transition activities, as necessary.

6. Conduct provider training sessions on new billing procedures, forms, policies, and AMMIS processing, with assistance from the Agency policy specialists.

7. Conduct training of Vendor call center and support staff in relevant knowledge of Agency Medicaid and Medicare programs, using training materials reviewed and approved by the Agency. This training must be completed before the system can go live.

8. Print and distribute all Alabama-unique claim forms and other required billing documents.

9. Prepare, print (or burn to CD/DVD), and distribute User Documentation and Provider Manual.

10. Control and store all transition-period claims until Agency approval of the Vendor's notice that the AMMIS is fully operational for all claim types.

11. Begin processing claims, for all claim types, with routine AMMIS operations starting on a date approved by the Agency.

12. Define plans and procedures for determining and documenting pass-through expenses.

13. Meet with the Agency as requested (daily, semi-weekly, weekly or bi-weekly) to discuss post-implementation issues.

14. Following the Implementation Task, the Vendor must prepare updates to the AMMIS Systems Documentation incorporating all changes, corrections, or enhancements to the AMMIS. Updates to the AMMIS Systems Documentation must be delivered to the Agency within ten (10) days of Agency approval of implementation of the change, unless otherwise agreed to by the Agency.

2.03.06.02 OIP Operations Implementation Milestones

The Operations Implementation milestones consist of the project deliverables defined for this phase and the following tasks:

- Deliverable templates for deliverables from this phase
- Project Management Bi-weekly Status Reports
- RTM with the final updates from the Implementation Phase
- Agency acceptance of the new AMMIS
- Completion of all activities identified in the training plan and the implementation plan

- Completion and Agency approval of all OIP task deliverables with changes or additions identified during previous operations implementation phases

- Installation of the approved user manuals, documentation and AMMIS Operating Procedures in an on-line or web based system library

- Demonstration that AMMIS financial data and claim inventory counts are being verified through routine balancing procedures

- Demonstrations that all AMMIS claim types are being processed at production volumes and within timeliness of claims processing requirements, as defined in *Section 3 – Requirements* of this ITB

- Demonstration that system reports are being delivered to Agency users according to the performance requirements, as defined in *Section 3 - Requirements*.

2.04 Enhancement Implementation Phase (EIP) - Statement of Work

The five (5) tasks defined for the scope of work in the Enhancement Implementation Phase include:

1. EIP Contract Start-Up & Project Planning
2. EIP Requirements Definition Plan
3. EIP Construction
4. EIP Testing
5. EIP Implementation

The Vendor shall define entrance and exit criteria for each phase. The Agency recognizes that the Vendor's systems development methodology may not match these tasks as defined. Where Vendor definitions of tasks differ, a cross-reference with entrance and exit criteria of the Vendor's tasks to the ITB listing is required.

The objectives for each task have been identified below. Deliverables and required contents are defined, although the Agency recognizes that Vendor proposed design methodologies and development tools may result in different products at different project phases and may include unique naming conventions. Initial milestones for each task are listed to ensure that adequate progress can be measured. These milestones must be cross-referenced to Vendor identified products.

If a new vendor is awarded the contract, they may use templates or plans from the Operations Implementation Phase, with updates for this phase and the Agency's approval. This is noted throughout the EIP section with the comment "(existing may be used)".

Task-level descriptions of the scope of work are presented in the following subsections.

2.04.01 EIP Contract Start-Up and Project Planning Task

The objectives of the EIP Contract Start-Up and Project Planning Task are to:

- Finalize the work-plan and schedule
  - Update to reflect the actual contract/phase start date
  - Update to reflect joint detailed planning with the Agency
  - Update to reflect the availability of Agency resources
  - Update to reflect all tasks and subtasks, along with the completion date for each

  - Conduct a Vendor quality review of the plan before submission to the Agency

- Define Deliverable templates
  - Identify templates for start-up phase
  - Discuss, refine, and finalize contents for Vendor deliverables
  - Identify criteria for Agency Approval

- Define quality and reporting metrics
  - Develop proposed metrics
  - Present proposed metrics for Agency approval
  - Implement Agency approved metrics

- Develop the Detailed Implementation Schedule (DIS)
  - Define the DIS based on Agency approved work-plan and schedule
  - Define the cost allocation data
  - Define the resource availability and usage
  - Maintain the DIS throughout the Implementation Phase
  - Provide work-plans and schedules bi-weekly or when requested

- Establish Test Environments
  - Verify hardware and software installs
  - Establish connectivity and communications

- Establish an issue tracking process and issue tracking software
  - Define the issue tracking process
  - Present the issue tracking process and software for Agency approval
  - Conduct training for Agency & Vendor staff

- Initiate project management control and reporting procedures
  - Define Control and reporting procedures
  - Present control and reporting procedure for Agency approval
  - Begin control and reporting procedures

- Conduct group reviews of all deliverables from this phase.

Project planning during this task includes detailed discussion of the overall implementation work-plan and finalization of the detailed work-plan for all tasks related to the Enhancement Phase of the project. Planning Task activities will include briefings, presentations, and training in the proposed system development life cycle methodology and any software tools the vendor proposes. The Agency reserves the right to deny the use of any software it feels will negatively impact the project. Vendor proposed deliverables/products for the Enhancement Phase will also be reviewed, discussed, and finalized during this task.

The Agency encourages the Vendor to use software tools for project tasks and documentation. Any proposed automated tool set may be used to develop and maintain

an integrated data dictionary, and panel and report layouts. The selected approach shall incorporate significant and continuous user involvement.

The Project Planning Task will result in a Final work-plan and Schedule reflecting the detailed work breakdown, staffing, deliverables, and schedule for all Enhancement Phase activities.

2.04.01.01 EIP Project Start-up Task Deliverables

The deliverables defined below are due within twelve (12) weeks of contract signing for the incumbent Vendor or within twelve (12) weeks of the start of the enhancement phase for the non-incumbent Vendor.

1. Final work-plan and Schedule - The Final work-plan and Schedule shall incorporate all Agency and Vendor tasks and activities and provide a detailed plan describing plans and contingencies to ensure an on-time, on-budget implementation. The Final work-plan and Schedule will be used by both the Agency and Vendor to monitor and manage the system enhancement implementation effort. The Vendor will work jointly with the Agency to review, revise, and finalize the work-plan. The Vendor will be responsible for making all revisions to the work-plan.

   The Final work-plan and Schedule shall include: an updated approved project schedule, work-plan, project objectives and scope, description of the project and deliverables, project assumptions, system life cycle description, listing of tools required, estimating assumptions, project milestones, project closure activity descriptions, project organization and staffing (including a staff loading chart for each task and for the entire phase), project interfaces, and project reporting approach. It shall address all milestones defined in this ITB with an expected date that the milestone will be met. A Gantt and a PERT chart showing all tasks, dependencies, and a critical path analysis shall be provided.

   The Final work-plan and Schedule submitted during this task will be presented at its most finite level of detail for the EIP Tasks. The work-plan must be organized by the tasks specified in this section and the system functions described in *Section 3 - Requirements*. It must also address all deliverables and milestones defined in this ITB with an expected date that the milestones will be met.

   The Final work-plan and Schedule shall be developed using an automated project management software tool. The tool and schedule supplied by the Vendor shall be the same tool and schedule the Vendor uses for internal project management. The Vendor shall provide an electronic copy of work-

plan files and ten (10) copies or licenses of the project management software for Agency use.

The Final work-plan and Schedule once approved will be base-lined. Any deviations of +/- seven percent (7%) will require submission and Agency approval of a Project Change Request form.

2. Detailed Implementation Schedule (DIS) - The DIS will be used by the Agency to monitor and manage the system enhancement implementation effort. In the DIS, the Vendor will provide an updated approved work schedule, work-plan, description of project deliverables, project resource requirements, and project management, approach to project interfaces, project reporting procedures, and updates to project cost and cost allocations. The DIS will be a dynamic document that must be maintained throughout the Enhancement Implementation Phase. Updated work-plans and schedules must be provided to the Agency bi-weekly or as requested by the Agency.

3. Master Test Plan - This plan will define the Vendor's approach to testing, any tools that will be used and explain how the identified testing will work together to thoroughly test the AMMIS. The plan must include, but not be limited to the following information for each phase of testing:

   - The testing phase objective
   - Testing phase entrance and exit criteria
   - Testing phase reporting metrics

4. Project Organization and Staffing Plan – this will identify the project team members, define the organizational reporting structure and project staffing requirements. (existing may be used)

5. Project Charter - a one (1) to two (2) page summary of the project

6. Project Kick-off Meeting – a meeting to introduce everyone and generate enthusiasm for the project. The meeting will consist of a brief overview of the project and a definition of roles.

7. Risk Management Plan – an analysis of likely risks with both high and low impact, as well as mitigation strategies to help the project avoid being derailed should common problems arise

8. Communication Plan – the communication standards between the Vendor and the Agency. This will include the approach, the interfaces, working relationships and protocols. (existing may be used)

9. Quality Management Plan – the methods that will be used to ensure quality throughout the project. (existing may be used)

10. Issue Management Plan – the tools and methods that will be used to identify, track and resolve issues throughout the project. (existing may be used)

11. Deliverable Definitions – A template of each document with descriptions of the information to be provided in each section of the document. (existing may be used)

12. Project Management Bi-weekly Status Reports – status reports to be created bi-weekly throughout the project. (existing may be used)

13. Facility Security Plan – the temporary and permanent security measures for the Vendor facility. (existing may be used)

14. Project Orientation – this will identify Agency/Vendor interfaces and working relationships. It will also introduce the Agency to the Vendor's approach to the project and train (or schedule the training for) the Agency on the use of Vendor tools. (existing may be used)

15. Enhancement Plan – This plan will contain a high level overview of the process the Vendor will follow during the Enhancement phase including templates for the design phase. The Plan shall identify any interaction or dependencies between the requested enhancements. This plan shall be all inclusive, but it may point to the enhancement requirements definition documents or other enhancements plans for more specific information.

16. Configuration management plan – this document(s) will identify the details for migrating the software changes from development to production. (existing may be used)

17. Requirements traceability Matrix (RTM) – this matrix will track each requirement from the ITB through all phases of the project (e.g. design, construction, testing, implementation). The RTM will be bi-directional which will allow a requirement to be traced from the first phases to the last phases AND from the last phases to the first phases.

2.04.01.02 EIP Project Start-up Milestones

The project start up milestones consists of the project deliverables defined for this phase and the following tasks:

- Deliverable templates for deliverables from this phase and the Requirements Definition phase
- Project Management Bi-weekly Status Reports
- Vendor tool Training and/or training schedule

- Implementation of the issue tracking process
- Implementation of the quality management process

2.04.02 EIP Requirements Definition

The objectives of the Requirements Definition Task are to identify, plan and document all changes required to implement the enhancements to the AMMIS. This phase will provide the detail information for enhancement identified in *Section 3 - Requirements* of this ITB.

2.04.02.01 EIP Requirements Definition Task Deliverables

1. Enhancement ### (Enhancement Number) Design Document – The Vendor shall develop one Enhancement ### document for each enhancement identified in this ITB. The Enhancement ### document shall identify all functional areas impacted by the enhancement, the dependencies on other enhancements and the implementation approach for the enhancement.

2. Requirements Definition Joint Application Development (JAD) Sessions – The Vendor shall request and facilitate meetings with the Agency Enhancement owners. These meetings will be used to clearly define the requirements for the enhancements. The Vendor shall request the meeting with an agenda through the Agency designated Point of Contact (POC). The Vendor will facilitate the meeting and produce meeting notes within three (3) days of the meeting. The meeting shall also produce requirement documents for each enhancement. The numbering for the requirements shall be the same as the number for the enhancement taken to the next level. For example: the requirement is #123. The first enhancement will be #123.1 the second enhancement will be #123.2, etc. The requirements document shall require Agency approval. When Agency approval is received the requirements and all supporting documentation will be added to the requirement repository. Any changes to ITB defined requirements (including wording of the requirement) must have the approval of the Change Control Board.

3. Enhancement ### (Enhancement Number) Detail Design Documents (DDD) – The Vendor shall use the information gathered in the Requirements Definition JAD sessions to develop multiple detail design documents for each enhancement. Each document will address a specific area of impact and include supporting documentation. The Enhancement ### DDD shall require Agency approval.

4. Ancillary Enhancements Detail Design Document (DDD) – This document will contain the Vendor's approach to making modifications that impact any ancillary systems. There will be one document for each Ancillary system and it will address all enhancements that impact that system. The document will contain the

details of each enhancement and how the Vendor will address multiple changes to one system (if needed). Ancillary systems include, but not limited to:

- Provider Electronic Solutions (free software given to providers)
- Translator
- Automated Voice Recognition System (AVRS)
- Long Term Care Notification Software
- CROCS (Comprehensive Recipient Online Collection System)
- WEB

5. Summary of Enhancement Changes – this document will identify the changes by enhancement number and description for each functional area. The purpose of the document is to identify all areas requiring multiple changes and any enhancement impacting multiple areas. The document will define the Vendor's approach to making and implementing these changes. This document will also identify all internal and external training for the new enhancement. The Vendor shall schedule one or more meetings to walk the Agency through this document.
6. Data Conversion Documents – this document(s) will identify the details for converting all data, any data clean-up required, and the Vendor process for cleaning the data. Agency approval will be required for any changes to the data. This document may not be required as part of the Enhancement Phase.

2.04.02.02 EIP Requirements Definition Milestones

The Requirements Definition milestones consist of the project deliverables defined for this phase and the following tasks:

- Deliverable templates for deliverables from this phase
- Project Management Bi-weekly Status Reports
- RTM with updates from this phase
- Vendor/Agency meeting(s) on the summary of enhancement changes with approved meeting minutes

2.04.03 EIP Enhancement Construction Task

The objectives of the Enhancement Construction Task are to use the detail documents created in the EIP Requirements Definition tasks to make the changes required to the AMMIS. This phase will construct and unit test the enhancements. The phase shall include but not be limited to:

- Develop the changes to the AMMIS.
- Perform unit and subsystem testing to ensure that the modification works correctly and will appropriately adjudicate all Medicaid claims, make all types of updates, and produce required reports and other outputs.
- Perform unit and subsystem testing on all internal and external interfaces to ensure that the enhancement process appropriately.
- Perform ancillary test such as but not limited to: Automated Voice Response System (AVRS), provider electronic solution software, long term care software, the translator, CROCS, the web applications and Electronic Claims Management (ECM) automated claims submissions to ensure that the AMMIS will appropriately answer inquiries and adjudicate all Medicaid claims.
- Demonstrate, through detailed unit and subsystem testing, that the enhancement is ready to begin integrated system testing.

The Agency will closely monitor Vendor activity during the EIP Enhancement Construction Task through the use of structured walkthroughs. The purpose of the walkthroughs will be to demonstrate that completed application programs will perform as desired by the Agency. Walkthroughs will be scheduled weekly throughout the Construction and Testing Task and will be attended by Agency project personnel.

The Vendor will be required to demonstrate to the Agency, in structured walkthroughs, test results for all components of the AMMIS. During the walkthroughs, the Agency may identify further test cases or situations to be demonstrated by the Vendor in order to ensure that each functional area is adequately tested. The Agency will select the walkthroughs to attend based on a list of scheduled walkthroughs provided by the Vendor. As part of the walkthroughs, the Agency may request changes, additional documentation or additional test.

2.04.03.01 EIP Enhancement Construction Deliverables

1. Peer Reviews and Walk-Through – the Vendor shall conduct a peer review or walk-through of completed activities.

2. Unit and Subsystem Test Results – documented unit and subsystem test results to ensure that activities function correctly. These shall be presented or provided at Agency request.

3. Updated Enhancement Design Documents – update ALL documents (e. g. requirements definition, design documents) with changes identified during the construction and unit testing phase.

4. EIP Implementation Plan – documented step by step process that will move all enhancements from system testing to production processing. The document will address the inner-dependencies of the enhancements and may contain details about each enhancement. The Agency will look favorably on a plan that makes the move in multiple phases.

5. Draft Manuals and Documentation – a draft version of all user, provider and system documentation that require modification because of the enhancements shall be provided for Agency review. The Vendor may apply the EIP changes to the current manuals and documentation. The master version of all manuals is currently maintained on-line in a web based document repository. All manuals submitted for Agency approval must have changes clearly identified. The manuals and documentation shall be available on the intranet, the web, CD\DVD or in paper format as requested by the Agency. The document shall be formatted in a manner that facilitates changes such as the use of track changes and versioning. All manuals and documentation shall be written in a manner that is understandable by business or non-technical staff. All manuals shall use a common nomenclature.

6. Training Plan – the Vendor shall submit for Agency approval a training plan that includes Agency staff, providers and other training identified by the Vendor or Agency. Each training plan shall define the training evaluation criteria.

    - Agency Training Plan - The Agency Training Plan details all the activities leading up to, and including, the training of Agency user staff, at all levels and in all Agency locations, in the proper use of the AMMIS. Approximately three hundred (300) users in Montgomery will require training. Training for other Agency and District Office staff may take place regionally, as approved by the Agency. At a minimum, the training plan shall include:

        - An outline/agenda of each training session

        - A description of training materials

        - A description of training facilities

- A training schedule
- Plans for remedial training
- A methodology to ensure continued training during the Operations Phase for new staff or staff changing positions

- Provider Training Plan - The Provider Training Plan details all the activities leading up to, and including, the training of all provider types in proper billing procedures, use of claim correction forms, understanding of remittance advices, program policy, etc. At a minimum, the Provider Training Plan shall include:
  - A description of training materials
  - Examples of training materials
  - A training schedule for all provider types, by provider type
  - Locations for training
  - Plans for remedial training and ongoing training during operations

7. Updated Disaster Recovery/Business Continuity Plan (DR/BCP) – The Updated DR/BCP will contain any changes in the current DR/BCP required to support the enhancements identified in this ITB. The Vendor shall present the DR/BCP in a group review.

8. Test plans – The Vendor shall present the following plans in a group review. The Vendor shall submit the plan(s) to the Agency five (5) days before the group review. If requested, the Agency shall have an additional five (5) days after the group review to review the details of the plan. The Vendor shall make changes or additions as requested by the Agency. The system integrated testing, regression testing, stress testing or user acceptance testing shall not begin until the test plans are approved by the Agency. The plans include but are not limited to:
   - Integrated System Test Plan - (end-to-end testing) including test scenarios, cases and script
   - User Acceptance Test Plan – including the setup and support of Agency UAT test efforts.
   - Stress Testing Plan – including the methodology for simulating three hundred (300) concurrent users across all subsystems and all electronic transactions.

- Regression Testing Plan – including the methodology to determine when regression testing should occur.

2.04.03.02 EIP Enhancement Construction Milestones

The Construction Phase milestones consist of the project deliverables defined for this phase and the following tasks:

- Deliverable templates for deliverables from this phase
- Project Management Bi-weekly Status Reports
- RTM with updates from this phase
- A Vendor certification in writing that the AMMIS is ready for System Integration, Stress, Regression and User Acceptance Testing

2.04.04 EIP Enhancement Testing Tasks

The objectives of the EIP Testing Task are to fully test the enhancements to the AMMIS. The test case results must include updated documentation with changes tracked or a statement that no documentation update was necessary before receiving Agency approval. The testing phase shall include integrated system testing (end-to-end testing), Regression Testing, Stress Testing and User Acceptance Testing (UAT).

2.04.04.01 EIP Enhancement Testing Deliverables

1. System Test Results – The Vendor shall perform system testing which demonstrates the AMMIS is fully functional. The System testing will: identify data entered into the system, follow the data through processing and demonstrate the data is included in output reports and processes – otherwise known as end-to-end testing. The test results for all functional areas shall be presented to the Agency for approval. The Vendor shall execute additional test or retest as requested by the Agency.

2. Regression Testing – The Vendor shall conduct regression testing throughout all testing phases. The Vendor must include applicable regression test results whenever system modifications are made to areas to which Agency approval has been given regardless of phase.

3. Stress Testing – The Vendor shall conduct stress testing on the AMMIS and all ancillary systems. The test results shall be presented to the Agency for approval.

4. User Acceptance Testing – The Vendor shall present an AMMIS with enhancements for User Acceptance Testing. UAT shall be conducted by the Agency. The Vendor shall provide a tool to define, track and report UAT metrics. The Vendor shall also support the Agency in the UAT environment and testing. The support shall include, but not be limited to environment setup, test setup, data loads, data manipulation, general test and tool support, and issue resolution.

5. Updated Implementation Plan – The Vendor shall present an updated (with changes tracked) implementation plan forty-five (45) calendar days before the actual go live date. The updated implementation plan shall contain all lessons learned and changes identified in the EIP testing phases. The Agency shall have ten (10) days to review this and request changes or additions.

6. Updated Manuals and Documentation - an updated version of all user, provider and system documentation (with changes tracked) that contains changes identified during testing. The Vendor shall submit these updates to the Agency for approval.

7. Updated DR/BCP – an updated version of the DR/BCP that contains changes identified during the testing phase. The Vendor shall submit these updates to the Agency for approval.

2.04.04.02 EIP Testing Milestones

The Testing Phase milestones consist of the project deliverables defined for this phase and the following tasks:

- Deliverable templates for deliverables from this phase
- Project Management Bi-weekly Status Reports
- RTM with updates from this phase

2.04.05 EIP Enhancement Implementation Task

During the EIP Enhancement Implementation Task, the Vendor shall update documentation, conduct provider and Agency staff training, and prepare for the implementation of the enhancements. It is anticipated that the activities for this task will run concurrently with the activities in other tasks defined for the EIP.

2.04.05.01 EIP Operations Implementation Deliverables

1. Develop and submit to the Agency for approval the final version of all deliverables.

2. Provide orientation and training for all Agency personnel on any changes that result from the enhancements.

3. Ensure the AMMIS will have the most current versions of software and data available.

4. Prepare a draft notice to providers, with Agency approval, in which AMMIS enhancement activities are identified, as necessary.

5. Conduct provider training sessions on new billing procedures, forms, policies, and AMMIS processing, with assistance from the Agency policy specialists.

6. Conduct training of Vendor call center and support staff in relevant knowledge of enhancement changes, using training materials reviewed and approved by the Agency. This training must be completed before the enhancements are implemented.

7. Print and distribute all Alabama unique claim forms, HIPAA transaction companion guides and other required billing documents.

8. Prepare, print (or burn to CD/DVD), and distribute User Documentation and Provider Manual.

9. Begin processing claims, for all claim types, with routine AMMIS operations starting on a date approved by the Agency.

10. Meet with the Agency as requested (daily, semi-weekly, weekly or bi-weekly) to discuss post-implementation enhancement issues.

11. Following the Implementation Task, the Vendor must prepare updates to the AMMIS Systems Documentation incorporating all changes, corrections, or enhancements to the AMMIS. Updates to the AMMIS Systems Documentation must be delivered to the Agency within ten (10) days of Agency approval of implementation of the change, unless otherwise agreed to by the Agency.

2.04.05.02 EIP Implementation Milestones

The Implementation Plan milestones consist of the project deliverables defined for this phase and the following tasks:

- Deliverable templates for deliverables from this phase
- Project Management Bi-weekly Status Reports
- RTM with updates from this phase

- Agency acceptance of the enhancements
- Completion of all activities identified in the training plan and the implementation plan
- Completion and Agency approval of all EIP task deliverables with changes or additions identified during previous phases
- Installation of the approved user manuals, documentation and AMMIS Operating Procedures in an on-line or web based system library
- Vendor demonstration that AMMIS financial data and claim inventory counts are being verified through routine balancing procedures
- Vendor demonstrations that all AMMIS claim types are being processed at production volumes and within timeliness of claims processing requirements, as defined in *Section 3 – Requirements* of this ITB
- Vendor demonstration that system reports are being delivered to Agency users according to the performance requirements, as defined in *Section 3 - Requirements*.

REQUIREMENTS

This section presents the operational responsibilities and performance expectations required to support the AMMIS and the business activities of the Alabama Medicaid program. The Alabama Medicaid Management Information System (AMMIS) consists of all subsystems of the MMIS except the Recipient Subsystem. Each subsystem or function is described in an opening section that gives operational details concerning current business practices. This opening section for each subsystem is followed by the Vendor requirements for that business functional area. The Bidder must read all sections of the ITB to get a complete understanding of the requirements. Many requirements from the current contract have been modified to include performance measures and are not considered enhancements. Major system modifications or specified additional personal are considered enhancements and are documented in *Section 7.17 Appendix Q – AMMIS Enhancements* of this ITB. Contract terms between the Agency and the Vendor will be designed to provide clear guidelines regarding adherence to performance expectations.

The State of Alabama, like many states, is operating in a health care environment that is rapidly changing. We believe our current MMIS adequately meets the changing needs of the State for the foreseeable future with the exception of those enhancements that are defined in *Section 7.17 Appendix Q – AMMIS Enhancements*. For this reason, the State is seeking to continue operation of its existing MMIS with these defined enhancements.

The Vendor requirements are presented in the following order:

- Section 3.01 General Requirements
- Section 3.02 Provider Requirements
- Section 3.03 Recipient Requirements
- Section 3.04 Reference Requirements
- Section 3.05 Prior Authorization (PA) Requirements
- Section 3.06 Claims Requirements
- Section 3.07 Financial Requirements
- Section 3.08 Third Party Liability (TPL) Requirements
- Section 3.09 Drug Utilization Review (DUR) Requirements
- Section 3.10 Drug Rebate Requirements
- Section 3.11 Long Term Care (LTC) Requirements
- Section 3.12 Managed Care Requirements
- Section 3.13 Medical Services Requirements
- Section 3.14 Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Requirements
- Section 3.15 Management and Administrative Reporting (MAR) Requirements
- Section 3.16 Surveillance and Utilization Review (SUR) Requirements
- Section 3.17 Decision Support System (DSS) Requirements
- Section 3.18 Comprehensive Recipient On-line Collections System (CROCS) Requirements
- Section 3.19 Integrated Test Facility (ITF) Requirements

3.01 General Requirements

The AMMIS currently running in Alabama includes benefit plan processing, as well as a state-of-the-art N-Tier architecture. It divides the application into components so that they process on different networked computers. This design and supporting architecture delivers enhanced flexibility, scalability, and reliability, as recognized by the National Association of State Information Resource Executives (NASIRE) Award for innovative use of technology that the base system received after its initial implementation in another state.

The AMMIS is composed of different software components which are loosely coupled and arranged in various software and architectural patterns to enable ease of use, development and maintainability. The core components include the MMIS batch processing which was developed in the C programming language executing in a UNIX environment, and an n-tier web-based user interface written primarily in C#, utilizing Microsoft ASP.NET. The MMIS data resides in an Oracle 10g database. There are many other critical software components, involving letter generation, ad-hoc reports, optical character recognition, electronic storage of paper reports and forms, and EDI. The AMMIS network is composed of hardware residing at the Vendor account site in Montgomery, AL, and the corporate MMIS data center in another state.

The following are the General requirements identified by the Agency that must be met by the Vendor to support the successful operation of the Alabama MMIS.

New #	General Requirements
3.01.001	Hours of Operations - The Vendor shall ensure that on-line access to the MMIS and all its applications is available to the Agency and the interface agencies from at least 7:00 AM through 7:00 PM, Monday through Friday.
3.01.002	ECM (Electronic Claims Management) shall be available at least twenty-one (21) hours per day from 5:00 AM until 2:00 AM seven (7) days a week, three hundred sixty-five (365) days a year. The ECM includes all HIPAA electronic transactions and all AVRS (Automated Voice Response System) transactions.
3.01.003	All MMIS fields unless specifically identified by the Agency shall maintain audit trails of all changes to data. All updates to MMIS data and all rejected update transactions must be reported to the Agency. The Alabama MMIS shall maintain and provide an automated history (audit trail) of all update transactions, both batch and on-line, including: • Date and time of change, • "Before" and "after" status, • "Before" and "after" data field contents as displayed on the screen or report, • Operator identifier or source of the update, and • User ID.
3.01.004	The MMIS shall maintain audit trails to show the edit/audit errors applied to each claim and claim-related transaction (e.g., when a claim pended and then resolved).
3.01.005	The Vendor shall override edits/audits only on prior written approval from the Agency.

New #	General Requirements
3.01.006	All MMIS data shall be available to the state or federal government upon request. In addition to the files that are regularly scheduled to be delivered to the Agency, the Vendor shall provide a copy of any other file, along with documentation of its format, within ten (10) days of a written request from the Agency. Each Agency request shall identify the files and the version, sequence, media, and number of copies. The Vendor shall receive no additional compensation for production and delivery of such files.
3.01.007	The MMIS shall allow forward/backward movement in multiple screen displays. All search result screens must provide the capability to view the details associated with any specific search results and to return from the search results detail back to the original search results screen.
3.01.008	On-line help shall be available, and descriptive error messages shall be provided for all on-line errors. Help and error messages should be context-sensitive to the extent possible. Each panel and field displayed on the panel shall have meaningful help descriptions accessible on-line real-time from the panel or field as approved by the Agency. The help message shall not be a repeat of the field name, such as the amount field is used to enter an amount.
3.01.009	The system shall provide connection, through the State WAN gateway to the MMIS, for at least three hundred (300) Agency staff at the same time, without any degradation in performance.
3.01.010	The Vendor shall provide access to the MMIS by remote users, including providers, insurance carriers, pharmacies, etc., through a variety of communications channels and protocols in order to support client eligibility verification, electronic claims capture, point-of-service-prospective DUR and claim adjudication. The Vendor shall provide for access through a variety of access mechanisms, including, but not limited to: • Lease lines (if appropriate and required); • Dial-up telephone inquiry via toll free lines and • Internet access.
3.01.011	The MMIS shall store and generate "zip + 4" codes to be used on all mailings. The system shall also provide a capability to print postal service bar codes for addresses. The Vendor shall provide a USPS-approved software package to streamline mailings. The Vendor shall use any software or processes necessary for the Agency to receive the lowest mailing rate possible. The package shall include the following features: • Corrects misspellings in city and street name • Standardizes address elements to USPS specifications (i.e., NE, AVE, LANE, etc.) • Verifies/corrects/adds zip code, zip + 4 code, and carrier route code • Removes embedded spaces and rearranges street address, city, state, and zip information into the standard USPS format • Generates Postal Service Form 3553 (CASS) which must accompany every mailing submitted at an automation-based rate and verifies that the mailing meets USPS requirements • Generate a report of records that the product could not code to allow the vendor to manually correct the address • Prints a bar code on any address (label, notice, letter, or warrant) to be used for mailing. • Mail bundling and any processes that reduce mail cost shall be used • Maintain current US Postal standards.

New #	General Requirements
3.01.012	The MMIS and related processes shall accommodate century date processing. The system shall also accommodate leap year processing. Leap year processing must be handled in such a way as to eliminate the potential for problems such as double posting of transactions, abends of transactions or transactions disappearing.
3.01.013	The system shall be modified to process HIPAA EDI transactions in the ASC X12 4010 format and the ASC X12 5010 format concurrently. This shall allow the Agency to discontinue the use of ASC X12 4010 transactions with an automated error message being returned to the sender. The fiscal agent shall identify all vendors using 4010 transactions and generate notices announcing discontinuation of ASC X12 4010 support in advance of the discontinuation. The date for production of said notices shall be determined by the Agency.
3.01.014	The system shall be modified to process HIPAA EDI NCPDP 5.1 (interactive) and NCPDP 1.1 (batch) concurrently with HIPAA EDI NCPDP D.0 (interactive) and NCPDP 1.2 (batch) transactions concurrently. This shall allow the Agency to discontinue the use of NCPDP 5.1 and NCPDP 1.1 transactions with an automated error message being returned to the sender. The fiscal agent shall identify all vendors using NCPDP 5.1 and NCPDP 1.1 transactions and generate notices announcing discontinuation of NCPDP 5.1 and NCPDP 1.1 support in advance of the discontinuation. The date for production of said notices shall be determined by the Agency.
3.01.015	The MMIS shall be fully capable of processing, displaying, searching and reporting all data fields from all NCPDP and ASC X12 5010 transactions in all panels, reports, processes, etc.All fields, reports or processes, etc. currently using ICD-9 codes shall be capable of using ICD-10 codes without modification.
3.01.016	All areas of the MMIS shall be fully compliant with the finalized provisions of the HIPAA and related regulations.
3.01.017	The Vendor shall ensure that the MMIS facilitates auditing of individual claims. Adequate audit trails must be provided throughout the system and conversion programs to identify and track all changes to MMIS data and all edits and audits encountered, resolved, or overridden. System reports shall be produced monthly by the 5th day of the month and as requested by the Agency to demonstrate that audit trails are in place.
3.01.018	Provides capability for transaction response time to be consistent for all users directly interacting with the production environment, based on a common Web Portal access for network access point, processed and returned to the network access point; provides capability for: - Ninety percent (90%) of transactions to occur in four (4) seconds or less, - Ninety-five percent (95%) of transactions to occur in five (5) seconds or less, - Ninety-seven percent (97%) of transactions to occur in six (6) seconds or less, - Ninety-nine percent (99%) of transactions to occur in seven (7) seconds or less. Response time will be measured both at the Agency and Montgomery Fiscal Agent facility. The Vendor shall report on this quarterly by the 5th day of the month following quarter end. Variances of more than twenty percent (20%) in response time between the two (2) locations will be researched and documented by fiscal agent and Agency staff for improvement. The documentation will be in a format determined by the Agency.
3.01.019	The system shall be able to add, change and/or delete any/all system-maintained data via on-

New #	General Requirements
	line or batch update.
3.01.020	The system shall use, to the greatest extent possible, on-line, real-time updates from Agency approved data processing devices.
3.01.021	The system shall provide the ability to perform mass updates on any/all system-maintained data when directed to do so by the Agency.
3.01.022	The system shall maintain multiple versions of data and effective dates (start date and stop date) in machine readable form for the adjudication of original payment requests, adjustments, and voids for all payment request types, etc.
3.01.023	The system shall provide flexibility in automated systems to support changes in detailed business rules in a quick and accurate fashion through table driven edits.
3.01.024	The system shall balance all batch inputs, transactions processed, and outputs for all system-maintained data maintenance activity and transactions.
3.01.025	The system shall maintain as current all system-maintained data and ensure that only the most current, or most appropriate, information is used for processing in ECM and the MMIS.
3.01.026	All batch or mass updates to the system will produce at a minimum: - A detail report of records added, - A detail report of records changed, - A detail report of records deleted, - A detail report of any errors encountered during the update, and - A report of total records on the input file and a breakdown of how each record was processed.
3.01.027	The AMMIS shall minimally contain and utilize the following: - All data elements in Part 11 of the State Medicaid Manual, - Required data elements for mandated Electronic Data Interchange (EDI) standards, - All data elements in the current Alabama MMIS data element dictionary, - All data elements defined for collection in the health plan contracts, and - All data elements from the HIPAA electronic transactions.
3.01.028	All check write dates are a Friday. Reports from the check write shall be available to the Agency by delivery or in a report repository such as COLD the first working day after the Friday check write date.
3.01.029	The days specified in all requirements are business days unless otherwise stated. State holidays are not considered business days. All requirement due dates that fall on a State Holiday will be due the next business day.
3.01.030	The claims month end balancing file shall be delivered/transmitted to the Agency by the end of the week following the last check write of the month.
3.01.031	Month end reports shall be delivered or be available in the report repository the first working day after the last checkwrite of the month unless otherwise specified within the subsystem.
3.01.032	On request or ad-hoc reports requested before 2:00 PM shall be delivered or available in a report repository such as COLD with-in two (2) days of the request unless otherwise specified

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	within the subsystem.
3.01.033	On request or ad-hoc reports requested after 2:00 PM shall be delivered or available in a report repository such as COLD with-in three (3) business days of the request unless otherwise specified within the subsystem.
3.01.034	Reports that are not dependent on financial information shall be delivered or available in a report repository such as COLD on the following schedule unless otherwise specified by the subsystem: Daily reports shall be available by 7:00 AM the first business day after the data is available. Weekly reports shall be available by 7:00 AM the first business day after the data is available. Monthly reports shall be available by 7:00 AM the first business day after the data is available. Quarterly and Annual reports shall be available by 7:00 AM on the 5th business day after the end of the quarter or year.
3.01.035	All system reports generated for Agency use shall be available in the following format: - Eight and one-half (8-1/2) by eleven (11) inch paper, - Laser print with several font sizes available, - Single-sided or double-sided print, as requested, and - Landscape or portrait orientation, as appropriate or requested.
3.01.036	The Vendor shall ensure that all federal and state reporting requirements will be met by the modified MMIS. See the Alabama MMIS Reports Listing located in the Procurement Library.
3.01.037	Reports shall be stored in such a manner as to allow on-line access to and retrieval of report information using user-entered selection criteria. The Vendor shall provide user-friendly parameter- and/or menu-driven access to reports. At a minimum, any report shall be made available on paper, COLD, CD-ROM/DVD, on-line and other PC-compatible media, as requested by the Agency.
3.01.038	Authorized Agency staff will work with the Vendor to define the content, format, sort sequence, report media, distribution, and timeframes of scheduled reports. The Vendor shall include the capability to support automatic report production and distribution over the Agency's WAN.
3.01.039	At a minimum, the Vendor shall be required to furnish reports according to the following schedule: On-line, real-time reports as requested or batched overnight based on a user-selected option to reflect report processing times and size. Daily on-line reports by 7:00 AM and all other reports by noon of the following business day. Weekly reports and cycle processing reports on-line by 7:00 AM and all other reports by noon of the following business day. All reports shall be available in accordance with the Alabama MMIS Reports Listing located in the Procurement Library.
3.01.040	All reports, including copies, shall be examined for readability prior to delivery to the Agency. Report data will not be accepted in compressed format. On-line reports will be formatted to split data into readable views.
3.01.041	The Vendor shall be responsible for delivering all reports to the Agency in the quantity and media, and to the office specified by the Agency, for each report.

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3.01.042	Standard maintenance identified in the ITB will not require any notification or request from the Agency. The hours associated with these tasks will be billed as system maintenance not system modification. The list includes, but is not limited to: - Health care utilization data from other carriers, insurers, etc., used for comparison/actuarial purposes; the data could be in summary form or at the claim level of detail; - Health care coverage/eligibility data, including Medicare, from other insurers, employers, state or federal agencies, etc., used for third party editing and third party liability data matches to be performed by the Vendor at the Agency's direction; - Quarterly, Annual (or when received) updates of HCPCS procedure codes from CMS; - Quarterly, Annual (or when received) updates of Medicare rate data in HCPCS code formats (and any succeeding formats); - Sanctioned provider data from OIG, CMS, DEA, and other the State-specified sources; - National Provider ID; - National Payer ID; - Medicare deductible and coinsurance claims crossed over from Medicare carriers and intermediaries; - Provider license and certification information from Alabama and other state licensing agencies, as well as appropriate federal sources; - Payment request information (claims, etc.) from service billing agencies, providers, and clearinghouses; - Managed care rosters from managed care organizations (HMOs); - Annual diagnosis code updates; - Information and updates for drugs; - OSCAR files; - Cycle Monitoring; - HCPCS; - ICD-9/ICD-10; - CLIA; - Medicare pricing; and - Other sources and/or organizations, as specified by the Agency in specific subsystem requirements.
3.01.043	The Vendor shall identify a single point of contact for all external interfaces. This point of contact shall provide prior to the start of operations written procedures on the initial set-up of interfaces, modifications to interfaces and termination of interfaces. The written procedures must contain any forms required by the vendor and identify all information that must be supplied with a timeline defined for each step. The Alabama MMIS Interface List is located in the Procurement Library. Some interfaces may be defined in the requirements for the subsystems.
3.01.044	Data retention requirements apply to all system-related data unless explicitly stated for a specific type of data. The data shall be retained in electronic format.
3.01.045	The system shall maintain data in the Data Warehouse for at least sixty (60) months.
3.01.046	The system shall provide on-line real-time access to all data used in the Agency-related business activities, including but not limited to: Claims processing, payment requests, managed care, long-term care, recipient data, provider eligibility, third-party liability, utilization and any other areas specified by the Agency.
3.01.047	The data that is sent or received from any external entity including but not limited to: any state agency, other health plans, etc. shall be retained for twelve (12) months unless otherwise

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	specified.
3.01.048	The Vendor shall retain sixty (60) months of data resulting from exchanges with CMS and other organizations.
3.01.049	The Vendor shall retain sixty (60) months of Insurance exchange data.
3.01.050	The current system does not have a purge process. If the Vendor limits the amount of historical data that will be retained, the purge process must be defined to ensure that all subsystems remain synchronized (no orphan records). The purge process must be documented and approved by the Agency.
3.01.051	Data entered into, maintained, or generated by the modified system shall be retained and accessible according to 42 CFR 431.17 and State requirements, as directed by the Agency.
3.01.052	The Vendor's system shall maintain drug claims data on-line for at least sixty (60) months.
3.01.053	The Vendor's system shall maintain non-drug claims data on-line for at least sixty (60) months.
3.01.054	The Vendor's system shall maintain recipient data on-line for at least sixty (60) months.
3.01.055	The Vendor's system shall provide on-line inquiry, given appropriate access security and password protection, to any/all system-maintained files and data. Access shall be by alphanumeric code, English name, and/or data dictionary name, and shall be accessed by primary key or alternative index keys.
3.01.056	The security for all systems supported by the Vendor shall be rule defined roles.
3.01.057	The MMIS security system shall ensure that the MMIS is protected against unauthorized access according to state and federal guidelines. Additionally, all transmission lines and communications services and linkages between the system and State WAN shall be secure from unauthorized access at all times. The MMIS must include automated restrictions which include the ability to restrict access on an individual and field-level basis based upon the authorized security level of the individual. Specifically, the security system shall be able to protect sensitive data and provide a minimum of read and write controls at the individual file level. The security system shall restrict access at the application level to selected users.
3.01.058	System security features shall include the following: - Adequate on-line security checks, including security by individual, location, files, and fields before allowing access to any of the Agency files including data, software, resources, code or any other files resident with or accessed by the Agency. - Unique log-on IDs for each user authorized by the Agency to have access to the system. Required passwords that expire periodically and can be changed at any time by Agency personnel. - Inhibited display of passwords on the sign-on screen when entered by the user. - Automatic logs and reports of all unauthorized access attempts by terminal ID, user ID, date, and time. - Automatically logs a user off the system if there is no activity within an Agency-specified period of time; the period of time may vary by function. - Automatically disables access to any user or user group after three (3) unsuccessful log-on attempts.

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3.01.059	Full and complete back-up copies of all data and software shall be maintained and proficiently backed up weekly on tape and/or optical disk and stored in an approved off-site location. The Vendor shall maintain or otherwise arrange for an alternative site for its system usage in the event of a catastrophic or other serious disaster event. "Disaster" means an occurrence(s) of any kind whatsoever that adversely affects, in whole or in part, the error-free and continuous operation of the MMIS, and/or affects the performance, functionality, efficiency, accessibility, reliability, and security of the system. Disaster events may include but not be limited to natural disasters, human error, computer virus, or a malfunctioning of the hardware or electrical supply.
3.01.060	Back-up and disaster recovery features shall include the following: The Vendor shall establish and maintain a full and complete weekly back-up that is adequate and secure for all computer software and operating programs, databases, files, systems, operations, and user documentation (in electronic and non-electronic form). The weekly backups shall be stored in an approved off-site location. The Vendor shall establish and maintain incremental daily back-ups that are adequate and secure for all computer software and operating programs, databases, files, systems, operations, and user documentation (in electronic and non-electronic form). The Vendor shall establish and maintain complete daily back-ups of all data and software and support the immediate restoration and recovery of lost or corrupted data or software. Disaster planning documentation and procedures shall be approved by the Agency before system operations begin. All proposed off-site procedures, locations, and protocols shall be approved by the Agency in advance.
3.01.061	The Vendor shall demonstrate an ability to meet back-up requirements by submitting and maintaining a Disaster Recovery Plan that addresses the following: - Checkpoint/restart capabilities, - Retention and storage of back-up files and software, - Hardware back-up for the main processor, - Hardware back-up for data entry equipment, - Network back-up for telecommunications, - Disaster scenarios, - Alternative site location, and - Contact points and procedures.
3.01.062	The Vendor shall provide for a back-up processing capability at a remote site(s) from the Vendor's primary site(s) such that normal payment processing, as well as other system and the Agency services deemed necessary by the Agency, can continue in the event of a disaster or major hardware problem at the primary site(s).
3.01.063	In the event of a disaster, the Vendor shall specify the respective timeframes deemed reasonably necessary for complete recovery.
3.01.064	The recovery period, in the event of a disaster, shall not exceed two (2) calendar days for critical functions such as eligibility verification, ECM and NET. The recovery period, in the

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	event of a disaster, shall not exceed thirty (30) calendar days for all other MMIS subsystems.
3.01.065	The Vendor shall take all steps necessary to fully recover the data and/or system from the effects of a disaster and to reasonably minimize the recovery period.
3.01.066	The Vendor shall demonstrate a disaster recovery capability no less than every calendar year, in accordance with 45 CFR 95.621(f) using either the production or model office environment. The mock disaster recovery process will start with the disaster occurring, operations will be brought up in an off site location, there shall be transactions successfully processed for each subsystem at the disaster site. The system will then be brought up in the production or model office environment and the Disaster recovery processed transactions shall be demonstrated to be part of the production system. Agency users shall have equivalent functionality at the disaster recovery site as they have at the production site. The Agency or a designated representative shall participate in all phases of the mock disaster. The Agency or designated representative shall validate the processes and protocols executed in the mock disaster follow the vendor's disaster recovery plan.
3.01.067	If the MMIS becomes unavailable during the contract period, the Agency may require the Vendor to convert to the back-up site. In this event, the Vendor will not be allowed to return to the original MMIS without the approval of the Agency. The Agency approval will depend on the Vendor's ability to demonstrate that the MMIS is again fully operational, that all connectivity is available, that there will be no loss in data or functionality and that the Agency's WAN gateway can connect with the MMIS.
3.01.068	The Vendor shall have completed on or before December 31, 2012, and biennially thereafter on or before December 31st, an independent auditor's report on the Contractor's internal control structure policies and procedures placed in operation and test of operating effectiveness. The examination of the internal control structure shall be conducted and the report prepared in accordance with generally accepted auditing standards. Specifically, the examination and report must be in accordance with Statement on Auditing Standards No. 70 (SAS 70), codified as AU Section 324 in the Codification of Statements on Auditing Standards published by the American Institute of Certified Public Accountants. The SAS 70 shall be a Type II report (report on controls placed in operation and tests of operating effectiveness). The report should include tests at all sites involved in processing data for the Alabama Medicaid Agency.
3.01.069	The vendor shall present a plan of action for correcting all deficiencies found in the SAS 70 report within thirty (30) days of receiving notification of the deficiencies. The plan of action shall include processes and estimated completion dates. The plan must be approved by the Agency before it is implemented.
3.01.070	Field work for the auditor's report on the Contractor's internal control structure policies and procedures shall be accomplished by the independent auditor to include testing during at least three months in each of two (2) fiscal years so that one report covers two (2) fiscal years. For example, since the fiscal year ends September 30th, tests of the internal control structure could be performed for the months of July, August, September, October, November, and December thereby overlapping two (2) fiscal years.
3.01.071	The Vendor's selection of the independent auditor shall be subject to the approval of the State. The State of Alabama Department of Examiners of Public Accounts shall have input and approval of the scope of work and control objectives to be performed by the external auditor prior to beginning the reviews of controls and tests of operating effectiveness.

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3.01.072	The independent auditor performing the examination, shall within 30 (thirty) days of the date of its report, deliver copies of the report and all related management letters to the Contractor, the Agency, the CMS Regional Office, and to the State of Alabama Department of Examiners of Public Accounts. The cost for the examination referred to above will be the responsibility of the Vendor. The Agency reserves the right to share the contents of the SAS 70 report with other entities as deemed necessary in the furtherance of the objectives of the Agency.
3.01.073	Since the examination described above is not intended to fully satisfy all auditing requirements of the State, the Agency reserves the right to have its entire operations audited by the State Department of Examiners of Public Accounts, including the operation of the Alabama MMIS and all aspects of the Vendor's operations which have an effect on the Alabama MMIS, at any time.
3.01.074	The Agency requires that the Vendor maintain a facility within the city limits of Montgomery, Alabama in a location approved by the Agency.
3.01.075	The Montgomery site shall be the location for ninety-percent (90%) of the system maintenance and modification team support as described in Section 6.07.02 Contract Required Personnel of this ITB.
3.01.076	The Montgomery site shall provide the capability to retrieve and print reports.
3.01.077	Courier service to the Agency site with pickup and delivery service twice each day. One (1) run shall be in the morning and the other in the afternoon.
3.01.078	The Vendor may perform other MMIS functions, including computer processing, outside of Alabama but within the continental United States. The site of computer processing shall be approved by the Agency.
3.01.079	All contract administration must take place at the Montgomery site and all key personnel must be housed at the Montgomery site.
3.01.080	The Montgomery site shall perform Claims receipt, prescreening, data entry, and transfer of claims and other non-electronic documents to Computer Output to Laser Disk (COLD).
3.01.081	The Montgomery site shall perform data entry or scanning of hard-copy claims.
3.01.082	The Montgomery site shall perform Exception claims processing suspense resolution.
3.01.083	The Montgomery site shall perform all business financial operations (accounts receivable handling, cash activity).
3.01.084	The Montgomery site shall perform Provider relations and enrollment.
3.01.085	The Montgomery site shall perform Prior authorization processing.
3.01.086	The Montgomery site shall house Medical professional specialists.
3.01.087	Key personnel for the Operations Phase of the contract include: Account Manager, Customer Relations Manager, Operations/Claims Processing Manager, and MMIS Systems Manager.
3.01.088	Contract required personnel for the Operations Phase of the contract include: EIS/DSS Technical support, Customer Relations staff, EMC Coordinator, Modification Teams, HCPCS Coordinator, SURS Analyst, TCM (Targeted Case Management) Prior Authorization

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	Coordinator, Medical Policy Specialist, Quality Assurance Manager, Provider Quality Assurance Evaluator, Systems/Technical Support and a total of two (2) Medical Policy Analysts of which one (1) shall be a Registered Nurse in the State of Alabama and a Certified Professional Coder (CPC) through the American Academy of Professional Coders and the other shall be at a minimum a Certified Professional Coder (CPC) through the American Academy of Professional Coders.
3.01.089	All contract required personnel not identified in the proposal shall be identified and submitted for Agency approval no later than thirty (30) days prior to the required start date for the position. Continuity in the following four (4) positions is not required between the Implementation and Operations Phases of the contract: Account Manager, Operations/Claims Manager, Customer Relations Manager, MMIS Systems Manager (may be MMIS Implementation Manager)
3.01.090	Personnel commitments for named key staff, designated supervisors, and systems professionals shall not be changed without prior approval from the Agency, unless due to the resignation or termination of any named individual. Any redirection of personnel, either temporarily or permanently, shall require prior written approval from the Agency. The Vendor shall supply the Agency with an updated organization chart and staffing plan whenever a key person is replaced, reassigned or reorganization takes place. The general responsibilities, minimum qualifications, and start date for these personnel are summarized in Appendix H. These contract required personnel and their immediate staff shall be located at the Vendor's local Montgomery facility.
3.01.091	The Vendor shall develop plans for managing and reporting on Vendor activities. The reports shall be produced within five (5) days following the close of the month. The report shall include but not be limited to: 1 - Detailed monthly management status reports, 2 - Activities, by each function or unit of the Vendor organization (e.g., Claims, Provider Enrollment and Relations, etc.), 3 - A monthly report, cumulative to the fiscal year end, summarizing Vendor activities and key volume indicators.
3.01.092	Establish and participate in bi-weekly operational status meetings with key Agency personnel to discuss progress, issues, problems, and planning. The Vendor shall report on current operations status, progress on system maintenance, and modification activities separately. The Vendor shall be responsible for preparing and distributing a meeting agenda. The Vendor shall be responsible for preparing and distributing draft meeting minutes for Agency review no later than 4:30 PM the third (3) day following the status meeting.
3.01.093	The Vendor shall limit access to its off-site and local facilities, including storage facilities, and provide the Agency with a copy of its security plan and procedures for all facilities. Security from threats and hazards at Alabama and out-of-state locations shall meet security guidelines specified in 45 CFR 95.621(f). The Agency reserves the right to perform physical security checks at the Agency's discretion.
3.01.094	All original hard-copy claims shall be maintained and retrievable either manually or automatically within twenty-four (24) hours of request until all claims in a batch are adjudicated. The Vendor is responsible for proposing a document disposal plan for the destruction of all hard-copy claims and claim-related material subject to Agency approval. Claims may not be destroyed until the related back-up (e.g., optical storage) has been checked for readability and compliance reported to the Agency. Quality assurance standards

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	for readability and claims destruction must have prior approval by the Agency and must adhere to strict QA standards.
3.01.095	The Vendor will determine the hardware configuration for the operation of the Alabama MMIS and related system functions. The hardware must be able to interface with the State's Information Systems Division (ISD) and be able to transmit and accept data in multiple media including direct data transmission. A list of State hardware and software is presented in the Alabama Medicaid Hardware for 2011 in the ITB Procurement Library. The system shall provide sufficient computing hardware to support all of the business functions described in the ITB. The Vendor must ensure that 1) the selected platform for the Alabama MMIS is fully compatible and demonstrable in a production environment with the proposed MMIS and related software and the selected operating system and 2) it is manufactured and/or sold by fiscally stable hardware provider(s).
3.01.096	The Vendor shall acquire and maintain all operating systems software necessary to operate the Alabama MMIS on the proposed hardware configuration. Software necessary under this proposed contract includes but is not limited to the operating system, compilers, debugging tools, all computer operations, data management utilities, necessary report writers, and user interface (UI), etc.
3.01.097	The Vendor may propose any nonproprietary applications programming language(s) for the Alabama MMIS. However, the language(s) shall be widely used, technically appropriate for the application, and compatible with CMS MMIS certification requirements. All proposed languages shall be subject to evaluation and approval by the Agency.
3.01.098	All software applications that support the operation of the MMIS must 1) be compatible with the hardware and operating environment installed at the Agency/State, 2) be compatible with the Agency/State local area network, and 3) support interfaces with other Agency systems. The Vendor shall be responsible for providing initial and ongoing training to Agency personnel on accessing and using the MMIS. The software shall be capable of operating in a Windows environment. The Vendor shall be responsible for handling upgrades and site licenses for the software. These licenses shall be in the Agency's name.
3.01.099	The Vendor shall be responsible for providing all computer resources, including peripherals, necessary for Vendor staff to perform their contract functions as described in the ITB.
3.01.100	The Agency encourages the introduction and use of modern technology, as appropriate, to meet Alabama's MMIS needs. The proposal of such technology will be favorably considered, provided that the new hardware and software enhances the functionality of the system without undue risk in the implementation process and is continually maintained and upgraded by the Vendor. See Alabama Medicaid Hardware for 2011 located in the ITB Procurement Library.
3.01.101	All hardware (workstations, file servers, printers and other peripherals, etc.) installed at Agency facilities shall become the property of the Agency. All software shall be licensed in the name of the Agency.
3.01.102	The Vendor shall provide and maintain all necessary software and communications hardware and middleware to support all electronic communications involved in day-to-day activities associated with the contract.

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3.01.103	The system shall include appropriate checkpoint/restart capabilities, and other features necessary to ensure reliability and recovery, including telecommunications reliability, file backups, and disaster recovery.
3.01.104	The Vendor shall provide and maintain communication lines, a gateway server, routers, CD-ROM server and associated peripherals. The Agency users shall be able to access the Alabama MMIS from their PCs connected to the State WAN. The Vendor shall provide the Agency with on-line inquiry and limited update access to all MMIS files through the State's WAN. See Alabama Medicaid Hardware for 2011 located in the ITB Procurement Library.
3.01.105	All systems and system components that are modified over the life of this contract shall be modified using structured design and programming techniques. The Vendor shall provide designated Agency technical staff with the capability to access and browse production and test source libraries, and production and test files. This capability shall be available at any time with the exception of scheduled down time.
3.01.106	The system shall easily accommodate the Agency-required changes to detailed business functions and/or system processing and permit system required changes to be executed in a quick, easy, and accurate fashion through user-performable, table-driven edits and updates.
3.01.107	The system shall be able to easily and rapidly change the data structure so that data elements, fields, or values can be added, changed, or updated; or the lengths of data fields can be expanded as required by the state and federal.
3.01.108	The Vendor shall provide all necessary software to support all electronic communications involved in day-to-day activities associated with the contract. The Vendor shall provide for electronic link to the State's WAN for approximately six hundred (600) users.
3.01.109	The system shall enable all assigned Vendor personnel to easily and rapidly exchange documents and electronic files with the Agency in compatible formats. This includes: Word Processing documents, Spreadsheets, Project Management files, data files.
3.01.110	This section identifies the major interfaces that shall be supported by the Alabama MMIS. The purpose of these interfaces is to provide for the direct transfer of data between systems to support Agency functions. The major interfaces include but are not limited to the following: The AMMIS shall provide a system interface with the Automated Voice Response System. The AMMIS shall maintain a systems interface with the ECM. The AMMIS shall provide any additional interfaces defined in each functional area. The AMMIS shall provide an interface for nightly file receipt and transmission of eligibility data.
3.01.111	The system shall maintain an adequate back-up and recovery system in compliance with federal and state rules and regulations. Full and complete back-up copies of all data and software shall be maintained and proficiently backed up on tape and/or other appropriate media. The Vendor shall ensure that back-up copies are stored in a secure off-site location, and that tests are routinely and proficiently performed on back-up copies.
3.01.112	The Vendor shall produce summary reports of payouts and recoupments for reporting and analysis. 1. The Vendor shall maintain a separate file cabinet in a report repository such as COLD to allow the individual transaction to be displayed. This shall be like Remittance Advices (RAs) presently are in a separate file cabinet to allow individual provider numbers to be displayed.

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	2. The Vendor shall utilize Agency approved reason codes. 3. The Vendor shall ensure when these transactions are keyed, a tracking number (case number) is generated. This number shall be the index number in COLD to display the individual transaction.
3.01.113	The Vendor shall produce an annual report of suggested improvements with high-level estimates of effort for each subsystem. These reports will be submitted to the Agency before the end of the first quarter of the calendar year. A meeting will be scheduled with the Functional Process owner and Agency representatives one (1) week after delivery of the report.
3.01.114	All meetings must be scheduled through the Agency representative by e-mail. The e-mail must contain "meeting request" in the subject line and it must allow a minimum of two (2) days for the meeting to be scheduled. The Vendor shall be responsible for preparing a meeting agenda that will be attached to the meeting request. The Vendor shall be responsible for preparing and distributing draft meeting minutes for Agency review no later than 4:30 PM the third (3) day following the meeting.
3.01.115	The Vendor shall perform cycle monitoring, internal team meetings, software configuration management, release management and all quarterly and annual reoccurring file updates (including SURS control files or equivalent functionality) as system maintenance tasks. These tasks will not be billable or use system modification hours.
3.01.116	The Vendor shall provide a secured method of exchanging data with the Agency. This method shall be bi-directional (from the Vendor to the Agency and from the Agency to the Vendor).
3.01.117	The Agency or a designated representative shall be notified and have access to all Vendor meetings, this includes but is not limited to team system meetings and Model Office walkthroughs. The Agency shall participate in the meetings at their convenience. This does not include Vendor personnel meetings or Vendor internal budget meetings.
3.01.118	The Agency reserves the right to verify requirements at any time using standards deemed appropriate by the Agency. In the event that a requirement is not met, the Vendor shall provide a corrective action plan within five (5) days. Once the Agency approves the corrective action plan, the plan will be implemented within five (5) days.
3.01.119	In the event of the Vendor's failure to either A) produce the corrective action plan within the required time frame or B) implement the corrective action plan within the required time frame, the Agency reserves the right to assess liquidated damages as specified in *Section 6 - General Terms and Conditions of the ITB.*
3.01.120	The Vendor shall maintain and provide maintenance for a dedicated T1 communication line between the State Data Center in the Capitol Complex and Contractor's computer for data transmissions using Connect:Direct File Transfer or a SFTP (Secure File Transfer Protocol) solution. The data exchanges can occur daily, weekly, monthly, etc. and they include but are not limited to eligibility (adds, changes), provider, DSS, reconciliation, claims, check-write, and MSIS.
3.01.121	The Disaster Recovery/Business Continuity Plan (DR/BCP) shall contain the physical addresses, building description and a map of all vendor locations referenced in the document.

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3.01.122	The DR/BCP shall identify the parties responsible for maintaining and updating the plan. The plan will also specify the review periods, the process to be used, and the approvals required.
3.01.123	The DR/BCP shall contain the company name, address, telephone number and a brief description of the service used for maintenance in the following areas: - Heat and Air Conditioning - Electricity - Natural Gas - Telephone - Water - Security (site & building) - Fire Detection and Prevention
3.01.124	The DR/BCP shall contain the on-site and off-site emergency & evacuation procedures.
3.01.125	The DR/BCP shall contain the roles and responsibilities for all on-site and off-site personnel.
3.01.126	The DR/BCP shall define the service interruption levels with a description and an estimated recovery time for each level.
3.01.127	The DR/BCP shall contain a business process impact analysis with a recovery priority by business area, a level of service required by each area and an estimated recovery time.
3.01.128	The DR/BCP shall contain a strategy for redundancy with estimated recovery times.
3.01.129	The DR/BCP shall contain a strategy for prevention with documented processes and procedures.
3.01.130	The DR/BCP shall contain a strategy for responsiveness and recovery which defines back-up process and procedures for all business and systems areas. The strategy shall specify the name, address, building description and responsibilities of all on-site and off-site locations.
3.01.131	The DR/BCP shall contain recovery strategies and scenarios which include on-site and alternate site recovery. The strategies and scenarios shall include but not be limited to bomb threats, chemical exposure, civil disturbances, communications failure, computer crime, theft of data, equipment failure, fire, hazardous materials release, intrusion, power failure, radiology accident, nuclear attack, weather emergencies, earthquakes, thunderstorms, tornados and winter storms.
3.01.132	The DR/BCP shall contain the process and procedures to return to the primary site.
3.01.133	The DR/BCP shall contain the processes and procedures to provide the all business functions. Each business function must be identified with an associated priority.
3.01.134	The DR/BCP shall contain a cross reference to identify each requirement from the ITB and how/where it is met.
3.01.135	The DR/BCP shall contain a quick reference of all roles with the employee name and contact information. Each role shall identify a back-up person with their name and contact information. This information shall be updated when personnel is added or removed from the vendors contract.

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3.01.136	The DR/BCP shall contain checklist for activities, strategies and scenarios.
3.01.137	The DR/BCP shall contain all emergency numbers for the vendor and the location.
3.01.138	The system, applications and data shall have incremental daily backups and full weekly backups.
3.01.139	The Vendor shall produce a quarterly production impact summary. The summary report shall identify the root cause of the impact which includes any change order or defect associated with the impact, length of impact, business areas impacted and user group (providers, recipients, Agency staff, Vendor staff, etc) impacted.
3.01.140	The Vendor shall have an in-house degausser for all media types received and/or maintained by the Vendor.
3.01.141	The Vendor shall submit a software release list five (5) days prior to the release being applied to the production environment. The release list shall contain all changes that will be applied to the production environment as part of the release. The release list shall identify all applicable issues (issue, change orders, defects, etc.) with the associated issue number, the business area impacted, the status of the WPR (work product review) and the date Agency approval was received.
3.01.142	The Vendor shall maintain a document imaging system that will be used to capture Agency identified documents the contractor receives or sends.
3.01.143	The repository used for the project documents and documentation must have an audit trail and versioning for all documents. This would capture date changed and changed by. It shall also retain a minimum of ten (10) previous versions.
3.01.144	All regularly scheduled file maintenance must be handled as an OPR not a CSR.
3.01.145	The Vendor shall have a set of state approved claims that run through an automated testing application after each software release to the UAT environment. The Vendor shall provide the Agency with a report on all claims that do not pay as expected. The report shall be to the Agency three (3) days prior to the release being applied to production. Agency approval shall be required before applying any production release that contains claims that do not pay as expected.
3.01.146	The UI panels shall display the data as codes and descriptions, not as SAK (system assigned keys). The SAK shall not be on the UI panels, used for UI sorting, UI selection or UI display sequence.
3.01.147	The Vendor shall apply any requirement that pertains to Agency staff to identified contractors upon Agency request.
3.01.148	The Vendor shall provide MMIS access to Agency-identified external entities upon Agency request.
3.01.149	The Vendor shall make the AMMIS HIPAA2-docket #CMS-0009-F compliant and retain the ability to concurrently process the HIPAA transactions.

New #	General Requirements
3.01.150	The Vendor shall modify the MMIS (including TPL) to concurrently transmit and receive Claims/Encounter transactions in the HIPAA X12N 4010 X098A1 (837 P), X12N 4010 X097A1 (837 D), X12N 4010 X096A1 (837 I) and the HIPAA2 X12N 5010 X222 E1 (837 P), X12N 5010 X224A1, E1 (837 D), X12N 5010 X223A1, E1 (837 I) formats.
3.01.151	The Vendor shall modify the MMIS (including TPL) to concurrently transmit and receive remittance advice in the HIPAA X12N 4010 X091A1 (835) and the HIPAA2 X12N 5010 X221E1 (835) formats.
3.01.152	The Vendor shall modify the MMIS (including TPL) to concurrently transmit and receive eligibility inquiries and responses in the HIPAA X12N 4010 X092A1 (270/271) and the HIPAA2 X12N 5010 X279E1 (270/271) formats.
3.01.153	The Vendor shall modify the MMIS (including TPL) to concurrently transmit and receive benefit enrollment and maintenance transactions in the HIPAA X12N 4010 X095A1 (834) and the HIPAA2 X12N 5010 X220E1 (834) formats.
3.01.154	The Vendor shall modify the MMIS (including TPL) to concurrently transmit and receive premium payment transactions in the HIPAA X12N 4010 X061A1 (820) and the HIPAA2 X12N 5010 X218E1 (820) formats.
3.01.155	The Vendor shall modify the MMIS (including TPL) to concurrently transmit and receive Authorization and Referral Request and Response (Non-Pharmacy) transactions in the HIPAA X12N 4010 X094A1 (278) and the HIPAA2 X12N 5010 X217E1, E2 (278) formats.
3.01.156	The Vendor shall modify the MMIS (including TPL) to concurrently transmit and receive Claim Status Inquiry and Response transactions in the HIPAA X12N 4010 X093A1 (276/277) and the HIPAA2 X12N 5010 X212E1, E2 (276/277) formats.
3.01.157	The Vendor shall modify the MMIS (including TPL) to concurrently transmit and receive Pharmacy Claim /Encounter transactions in the HIPAA NCPDP 5.1 (interactive), NCPDP 1.1 (batch) and NCPDP D.0 (interactive), NCPDP 1.2 (batch) formats.
3.01.158	The Vendor shall modify the MMIS (including TPL) to transmit and receive Pharmacy Supplies and Professional Services Claim/Encounter transactions in the HIPAA X12N 5010 X222E1 (837P) or NCPDP D.0 (interactive) and NCPDP 1.2 (batch) formats.
3.01.159	The Vendor shall modify the MMIS (including TPL) to concurrently transmit and receive Pharmacy Eligibility Inquiry and Response transactions in the HIPAA NCPDP 5.1 (interactive), NCPDP 1.1 (batch) and the HIPAA2 NCPDP D.0 (interactive), NCPDP 1.2 (batch) formats.
3.01.160	The Vendor shall modify the MMIS (including TPL) to concurrently transmit and receive Pharmacy Authorization and Referral Request and Response (Retail Pharmacy) transactions in the HIPAA NCPDP 5.1 (interactive), NCPDP 1.1 (batch) and the HIPAA2 NCPDP D.0 (interactive), NCPDP 1.2 (batch).
3.01.161	The Vendor shall implement the new NCPDP Batch Standard Medicaid Subrogation 3.0 transaction. The AMMIS shall be fully capable of processing and reporting all data fields from this transaction in all panels, reports, processes, etc.
3.01.162	The Vendor shall produce an impact analysis report on the ACS X12 5010 and NCPDP transaction changes. This report shall, by functional area, address all portions of the AMMIS. It will identify the changes that must occur, the benefit of the change and the resources

New #	General Requirements
	required to make the changes.
3.01.163	The Vendor shall provide an analysis to the highest specificity of the impacts that result with the transition from the ICD 9 to ICD 10. The analysis shall include but not be limited to: - new code to similar code/deleted code, - age, - gender, - BPA (Benefit Plan Administration), - recipient plan, - edits/audits, - diagnosis groups and ICD Surgical procedure groups, - crosswalks of all system and adhoc reports that utilize ICD codes, and - all other impacted portions of the AMMIS. All field lengths for ICD-10 shall match system wide. The Vendor shall provide an impact statement to the Agency during the Analysis phase of the Design, Development and Implement phase.
3.01.164	Outstanding change orders at the time of Implementation shall become the responsibility of the Vendor.
3.01.165	The Vendor shall recommend cost savings proposals to the Agency as described in *Appendix M of this ITB.*
3.01.166	The Vendor shall update all iTRACE documentation to reflect the new ITB Requirements and numbering.
3.01.167	The Vendor shall update all other documentation which currently references prior ITB Requirements and numbering with the new ITB Requirements and numbering.
3.01.168	The Vendor shall identify all change orders implemented which have resulted in additional or modified system functionality and draft new system requirements to reflect those changes for Agency approval by September 1, 2011.
3.01.169	The Vendor shall, as part of the implementation of all change orders or defects, identify and update the associated requirement(s). If there are no requirements for this change, the Vendor shall write the new requirement(s). The new or updated requirement(s) shall be submitted to the Agency for approval prior to implementation.
3.01.170	The Vendor shall as part of the implementation of any change orders or defects, update all other documentation with the new or updated requirement(s) and requirement(s) numbering. The modified documents must be presented to the Agency for approval prior to implementation.
3.01.171	The Vendor shall understand that a reference to MMIS or AMMIS includes any system or function identified in this ITB and any amendment to this ITB contract.
3.01.172	The Vendor shall comply with all federal HIPAA Privacy and Security Rules as if the Vendor was a covered entity.

New #	General Requirements
3.01.173	The Vendor shall designate a Privacy Officer and Security Officer. One individual may serve in the capacity of both Privacy and Security Officer. The Vendor shall obtain Agency approval of their Privacy and Security Officer designee(s).
3.01.174	The Vendor shall perform a bi-annual technical and nontechnical security evaluation based on the standards outlined in 45 CFR Part 164, Subpart C, Security Standards for the Protection of Electronic Protected Health Information, on or before December 31st. The evaluation shall be considered system maintenance.
3.01.175	The Vendor shall correct all deficiencies identified by the security evaluation to bring the Vendor into compliance with the HIPAA Security Rule. The correction of the deficiencies shall be considered system maintenance.
3.01.176	The Vendor shall present a plan of action for correcting all deficiencies found during the security evaluation within thirty 30 (thirty) days of completing the evaluation. The plan of action shall include processes and estimated completion dates. The plan must be approved by the Agency before it is implemented. The production of the plan shall be considered system maintenance.
3.01.177	The Vendor shall within 30 (thirty) days of the date of completing the HIPAA security evaluation provide the Agency a copy of the security evaluation report. The Agency reserves the right to share the contents of the security evaluation report with other entities as deemed necessary in the furtherance of the objectives of the Agency.
3.01.178	The Vendor shall notify the Agency no later than one (1) business day following the discovery of a breach of Protected Health Information (PHI).
3.01.179	The Vendor shall provide the following information and obtain Agency approval prior to reporting a breach as required by 45 CFR Part 164, Subpart D: - The number of recipient records involved in the breach. - A brief description of what happened, including the date of the breach and the date of the discovery of the breach if known. - A description of the types of unsecure protected health information that were involved in the breach (such as whether full name, social security number, date of birth, home address, account number, diagnosis, disability code, or other type information were involved). - Any steps the individuals should take to protect themselves from potential harm resulting from the breach. - A brief description of what the Vendor is doing to investigate the breach, to mitigate harm to individuals and to protect against any further breaches. - Contact procedures for individuals to ask questions or learn additional information, which shall include the Vendor's toll-free number, email address, Web site, or postal address. - A proposed media release developed by the Vendor.
3.01.180	After Agency approval, the Vendor shall provide the necessary notices to the recipient, prominent media outlet, or the Secretary of Health and Human Services (HHS) to report Vendor breaches as required by 45 CFR Part 164, Subpart D.
3.01.181	The Vendor shall pay all fines or penalties imposed by HHS under 45 CFR Part 160 HIPAA Administrative Simplification: Enforcement rule for breaches made by any employee, officer, or agent of the Vendor.

New #	General Requirements
3.01.182	The Vendor shall pay all costs associated with notifying the Agency, recipients, media outlets, and HHS for breaches made by any employee, officer, or agent of the Vendor.
3.01.183	The education and training of Vendor staff on CMS standard code sets and transactions such as ICD-10 and HIPAA 5010 shall be the responsibility of the Vendor. The hours shall not be billable hours.

3.02 Provider Requirements

The Provider Data Maintenance function maintains comprehensive, current, and historical information about providers eligible to participate in the Agency's medical assistance program. The establishment and maintenance of a single provider data repository with provider demographic, certification, rate, and summary financial information, supports accurate and timely claim records processing, enhanced management reporting, and utilization review reporting and surveillance activities. The Provider Data Maintenance function also maintains functions to support provider training activities. The AMMIS is capable of meeting the requirements of the National Provider Identification (NPI) standards of HIPAA. This requires identifying providers using the NPI and/or utilizing standards consistent with NPI and HIPAA requirements. This includes only one unique number for a provider, identifying all locations, provider types, specialties, authorization/certifications/licensing for services, and other required data for that provider as a logical record. The AMMIS Provider Data Maintenance function objectives are to:

- encourage the participation of qualified providers by making enrollment and re-enrollment an efficient and accurate process;
- ensure that providers are qualified to render specific services by screening applicants for state licensure and certification, and specialty certification;
- provide for the processing of provider contracts and changes in a timely and accurate manner;
- maintain control over all provider data;
- maintain all demographic and rate information to support claims processing and reporting functions and
- Provide timely, efficient telephone responses to provider eligibility inquiries from the Medical Assistance Customer Service Center, using up-to-date enrollment status information in the AMMIS

The following are the requirements identified by the Agency that must be met by the Vendor to support the successful operation of the Provider related functions.

New #	Provider Requirements
3.02.001	The Vendor shall maintain on-line, real-time the provider enrollment status with associated date spans. The enrollment codes must include but are not limited to the following:

New #	Provider Requirements
	- Active/Inactive Provider, - Deceased Provider, - Decertified, - Fraud & Abuse Provider, - Group, - Provider Number Bad Address, - Provider Number Cancelled, - Provider Purge/Deactivate, - Crossover Only, and - Credit Balance.
3.02.002	The Vendor shall maintain on-line, real-time all data elements currently required by the Agency for enrolled providers; including both active and inactive providers, on the Provider Master File (PMF). The PMF must include but is not limited to the following examples: - Provider IDs (NPI, Medicaid number, Base ID), - Provider name, - Provider Addresses (All to include city, county, state, 9-digit zip code, service location, pay to, mail to and home office), - Provider telephone/fax number, - Provider type, - Provider effective date, - Provider end date, - Tax ID, - SSN, - Medicare number, - Provider specialty, - Enrollment status, - Enrollment status effective and end date, - License number, - Sanctioned indicator, and - Managed care indicator.
3.02.003	The Vendor shall maintain on-line, real-time the Agency approved three (3)-digit provider specialty codes and two (2)-digit provider type codes.
3.02.004	The Vendor shall maintain on -line, real-time effective dates and end dates for: - provider contracts, - provider group membership, - enrollment status, - electronic media claims (EMC) billing data, - restriction and on-review data, - claim types, - billing categories of service, - certification(s), including Clinical Laboratory Improvement Amendments (CLIA) identification numbers, - specialty, and - other user-specified provider status codes and indicators.

New #	Provider Requirements
3.02.005	The Vendor shall accept on-line, real-time updates of review or restriction indicators and dates on a provider's record to assist the Agency in monitoring a provider's medical practice.
3.02.006	The Vendor shall maintain on-line, real-time multiple provider contracts for a single provider.
3.02.007	The Vendor shall maintain on-line, real-time providers' Drug Enforcement Agency (DEA) numbers.
3.02.008	The Vendor shall identify on-line, real-time out-of-state providers with an indicator on the provider file.
3.02.009	The Vendor shall identify on-line real-time and cross-reference multiple practice locations and practice types for a single provider.
3.02.010	The Vendor shall maintain on-line, real-time for a provider, multiple names, addresses, and telephone numbers, including but not limited to: - Pay-to, - Legal name, - Mail-to (remittances, bulletins, etc.), - Physical Address (4 lines), - Service location(s), - DBA name and address, - Telephone number/FAX number, - Degree, - Professional Titles, and - Home Office.
3.02.011	The Vendor shall maintain on-line, real-time the total number of Medicaid beds, total number of Medicare beds and the total number of both Medicaid and Medicare beds, long-term care facility certification effective dates and Alabama Department of Public Health survey inspection date(s), in addition to current State-specified data elements with unlimited date-specific segments for long-term care facilities and other state institutional providers.
3.02.012	The Vendor shall process on-line, real-time additions and changes to the provider master file within two (2) days of receipt of Agency request.
3.02.013	The Vendor shall maintain on-line, real-time a restrictive services panel which will allow the Agency to enter specific codes for restricting the services for which providers may bill to those for which they have the proper certifications (e.g., lab certification codes, restricted services).
3.02.014	The Vendor shall maintain the recipient file with changes in long term care provider's name and/or mailing address on-line real-time (e.g., if a nursing home has a name and/or address change, it must be updated in the recipient file also).
3.02.015	The Vendor shall process on-line, real-time retroactive rate changes to the provider file.
3.02.016	The Vendor shall edit all data for presence, format, and consistency with other data in the update transaction and on the provider master file.
3.02.017	The Vendor shall maintain the capability to accommodate non-medical providers on the provider master file (e.g., vendors, State Agencies, etc.), and maintain on-line, real-time the necessary data on such providers.

New #	Provider Requirements
3.02.018	The Vendor shall process and maintain on-line, real-time group NPI numbers and relate and cross-reference individual providers to their groups as well as a group to its individual member providers with appropriate multiple segments with effective and end dates.
3.02.019	The Vendor shall generate on a monthly basis a report that identifies any duplicate NPI, provider license or certification numbers, or SSN on the provider master file. The report shall be provided to the Agency by the 5th day of the month.
3.02.020	The Vendor shall monitor provider data with State licensure and certification data on a continuing basis, including data exchanges with State agencies, as appropriate. The Vendor shall ensure no claims have been processed and paid to providers who have not renewed their license.
3.02.021	The Vendor shall maintain agreements and indicators for billing agencies and for providers using electronic claims submission methods. The Vendor shall make agreements available on COLD.
3.02.022	The Vendor shall maintain on-line, real-time on the provider file for use in claims processing, providers who use automated submittal of claims, automated remittances, and/or automated funds transfer.
3.02.023	The Vendor shall maintain and allow on-line, real-time searches to summary information regarding provider year-to-date claims submittal and payment data.
3.02.024	The Vendor shall only pay claims using the NPI number.
3.02.025	The Vendor shall provide on-line, real-time search capabilities that will cross-reference the current Medicaid provider number to prior Medicaid provider number, Medicare provider number and NPI.
3.02.026	The Vendor shall maintain an on-line audit trail of all information, including provider name, NPI, provider number, Medicare number, or status changes, and date and source of change.
3.02.027	The Vendor shall maintain on-line, real-time multiple provider-specific reimbursement rates, including usual and customary charge rates; per diems; percentage-of-charge rates; or other cost-containment initiatives, with unlimited beginning and ending effective date segments. The Vendor shall maintain at least sixty (60) months of data.
3.02.028	The Vendor shall maintain on-line, real-time separate rates, as necessary, for specific programs, such as waivers and State-funded programs. The Vendor shall maintain at least sixty (60) months of data.
3.02.029	The Vendor shall maintain on-line, real-time the capability to selectively perform rate updates for all Alabama Medicaid programs in which a provider is participating or only for a selected program.
3.02.030	The Vendor shall perform mass updates to provider rate information. As needed updates must be processed within ten (10) days of receipt of OPR with effective date specified by the Agency. A large volume of providers' rates are updated with an effective date of Oct 1st each year.
3.02.031	The Vendor shall perform semi-annual, or as needed, mass updates to provider rate information for Nursing Homes. Semi-annual updates must be effective for Jan 1st and July 1st. As needed updates must be processed within ten (10) days of receipt of OPR with

New #	Provider Requirements
	effective date specified by the Agency.
3.02.032	The Vendor shall perform yearly, or as needed, mass updates to provider rate information for Hospitals. Yearly updates must be effective for July 1st. As needed updates must be processed within ten (10) days of receipt of OPR with effective date specified by the Agency.
3.02.033	The Vendor shall perform yearly, or as needed, mass updates to provider rate information for Routine Hospice. Yearly updates must be effective for Oct 1st. As needed updates must be processed within ten (10) days of receipt of OPR with effective date specified by the Agency.
3.02.034	The Vendor shall perform yearly, or as needed, mass updates to provider rate information for Nursing Home Hospice. Yearly updates must be effective for Jan 1st. As needed updates must be processed within ten (10) days of receipt of OPR with effective date specified by the Agency.
3.02.035	The Vendor shall perform yearly, or as needed, mass updates to provider rate information for LTC waivers. Yearly updates must be effective for Oct 1st. As needed updates must be processed within ten (10) days of receipt of OPR with effective date specified by the Agency.
3.02.036	The Vendor shall maintain on-line real-time the two (2) digit provider county and a two (2) digit locality indicator in the Provider Master File. The Vendor shall display the provider county name on-line.
3.02.037	The Vendor shall maintain an automated tracking and reporting system for provider requests, questions and complaints (from receipt to final disposition), including tracking and reporting on types of questions and types of providers, and maintaining information on which specific provider has a specific question or complaint. The Vendor shall work with the Agency to define the reports and provide to the Agency by the 5th day of each month.
3.02.038	The Vendor shall provide on a monthly basis operational reports about the number of Provider enrollment applications, updates and research items received during the month by day. The monthly report will cover the previous month's activity and be provided no later than 5th day of the following month. The report shall include but not be limited to statistics on the following: - beginning inventory; - ending inventory; - applications received; - applications keyed; - applications returned; - updates received; - updates keyed; - updates returned; and - research items processed.
3.02.039	The Vendor shall during enrollment, perform duplicate checks on tax ID, SSN, license number, and name. The Vendor shall ensure all provider numbers are linked together and cross-referenced to all inactive or old provider numbers and identify the current active NPI for that entity. The Vendor shall override duplicates when necessary.
3.02.040	The Vendor shall maintain on-line, real-time search and sort capabilities to the Provider Master File. Search capabilities shall include but not be limited to provider name, partial name with variable number of characters (including businesses, hospitals, clinics, etc.),

New #	Provider Requirements
	Provider IDs (NPI, Medicaid number, Base ID, group number) Medicare number, license number, SSN, UPIN, and Tax ID.
3.02.041	The Vendor shall allow inquiry and reporting capabilities to perform flexible selection of providers using parameters to include but not be limited to: provider type, provider name, provider doing business as (DBA), specialty, county, zip code or zip code range; display results on-line or allow requesting of hard-copy printouts.
3.02.042	The Vendor shall produce all provider reports currently being produced in the Alabama MMIS Reports Listing located in the Procurement Library according to the schedule determined by the Agency.
3.02.043	The Vendor shall provide the capability to generate alphabetic and numeric provider listings that can be restricted by selection parameters such as provider type, county, zip code, enrollment status, and specialty code.
3.02.044	The Vendor shall ensure on-line search will accommodate, at a minimum the information currently available, using the minimum number of panels practical. Examples of information are: - Basic information about a provider to be displayed on a single panel (e.g., name, location, number, provider type, specialty, certification dates, etc.) - Edit indicator and provider flags - Provider mnemonic inquiry - Provider rate data - Provider customary charges - Provider accounts receivable and payable data - Additional provider information, such as provider addresses (including physical location), DEA #, group and servicing provider data, and summary year to date claims (current and prior years), and submittal and payment data - For institutional providers, the total number of Medicaid beds, total number of Medicare beds and the total number of both Medicaid and Medicare beds in the facility and reimbursement rate - On-review data, specialty data (e.g., lab certification data).
3.02.045	The Vendor shall process the annual file received from the Internal Revenue Service that identifies providers with invalid tax name and/or tax number. The Vendor shall update the PMF to show the type of B Notice sent to a provider. The Vendor shall generate and mail the Provider First B Notice or Provider Second B Notice per Internal Revenue Service requirements. The Vendor shall begin withholdings on a provider in accordance with Internal Revenue Service instructions. The Vendor shall update the PMF to discontinue withholding when Internal Revenue Service's required information is received by the Vendor from the Provider. The Vendor shall produce the B Notice reports identified in the Alabama MMIS Reports Listing located in the Procurement Library. The Vendor shall comply with any Internal Revenue Service requirements on reports.
3.02.046	The Vendor shall produce and provide a report with cross-reference listings for FEIN, SSN, and license numbers on a monthly basis by the 5th day of the month. The report shall also be

New #	Provider Requirements
	produced upon Agency request.
3.02.047	The Vendor shall produce group mailings and provider labels based on selection parameters such as provider type, zip code, specialty, county, special program participation. The labels shall be delivered to the Agency within five (5) days of request.
3.02.048	The Vendor shall download on a weekly basis the CMS OSCAR file for information regarding laboratory certifications and update provider files as appropriate within twenty-four (24) hours of download.
3.02.049	The Vendor shall ensure they maintain knowledge of all applicable federal and state provider enrollment and certification regulations. The Vendor shall provide an impact report to the Agency that recommends changes to meet the modified regulations. The report shall be produced within ten (10) days of the regulation publication.
3.02.050	The Vendor shall develop and establish a plan with detailed guidelines and procedures, to include quality reviews, to ensure proper enrollment of all provider types. The Vendor's plan shall identify the processes that will be used to meet the Agency's quality thresholds. This plan must be approved by the Agency.
3.02.051	The Vendor shall perform enrollment activities for all provider types, both contract and non-contract providers. The Vendor shall maintain facility ownership information as a function of provider maintenance.
3.02.052	The Vendor shall use taxonomy code and location code to match NPI number to current Medicaid Provider ID.
3.02.053	The Vendor shall maintain agreements for billing agencies. This will include: - Administrative access for creating, deleting, setting permissions and resetting passwords for all trading partners. - User access for updating their profile to better fit the user's needs.
3.02.054	The Vendor shall maintain provider enrollment personnel with a minimum of ten (10) FTEs - Enrollment Specialists, one (1) FTE - Quality Assurance, and one (1) FTE Enrollment Supervisor.
3.02.055	The Vendor shall receive requests for enrollment and mail all enrollment packets to providers within two (2) days of receipt of the request.
3.02.056	The Vendor shall accept and process (approve or deny) provider applications within five (5) days of receipt. If additional information is required from the provider, an additional five (5) days is allowed to obtain the information and process the application. Provider enrollment applications shall be in the format specified by the Agency.
3.02.057	The Vendor shall add new providers, according to State guidelines, to the provider master file/database within two (2) days of enrollment approval.
3.02.058	The Vendor shall update the Provider File/Database on-line within two (2) days of receipt of change requests from any source. If additional information is required from the provider, an additional two (2) days is allowed to obtain the information and process the change request.
3.02.059	The Vendor shall research and compile all information relating to the Provider appeals process for provider enrollment rejections, terminations, and changes to program participation

New #	Provider Requirements
	eligibility effective dates in accordance with State guidelines. Submit the material to the Agency for its use in the provider appeals process within two (2) days of request.
3.02.060	The Vendor shall notify providers by letter of acceptance/rejection as a Medicaid provider, and send a start-up packet to approved providers containing all necessary information, forms and/or software needed to bill for Medicaid services for eligible recipients within two (2) days of enrollment determination.
3.02.061	The Vendor shall process, record, and track, using an automated tracking system, all sanctions and intermediate sanctions against providers, per State specifications, as initiated by CMS, the federal OIG or State. The record shall include the provider's full name and address, social security number, tax id, license number, and the begin and end dates of sanction, from written reports produced by CMS, or any other government agency. The Vendor shall compare the electronic file to the master provider file and report matches to Medicaid for further action within five (5) days of receipt of Medicare Exclusions Database (MED) file or Agency request.
3.02.062	The Vendor shall perform certification and recertification activities, as appropriate and directed by the Agency, to ensure that all Alabama Medicaid providers maintain required certifications for participation in the Medicaid program.
3.02.063	The Vendor shall prior to enrollment and on an Agency approved schedule verify and validate the Provider certification and licensure information with applicable state agencies and licensing organizations in Alabama, Florida, Georgia, Mississippi, Tennessee, and other states as required to perform certification and licensure verification. The Vendor shall perform electronic data exchanges when possible. The applicable agencies and organizations include but are not limited to the Alabama Department of Public Health, the State Board of Medical Examiners, the Joint Commission, and the State Boards (Dental Examiners, Optometry, Nursing, Psychology, Speech Pathology and Audiology, Occupational and Physical Therapy, Chiropractors and Podiatrists).
3.02.064	The Vendor shall provide the capability to ensure that all Contractors and providers and their subcontractors, meet all applicable federal facility certification and credentialing requirements.
3.02.065	The Vendor shall prior to enrollment and on an Agency approved schedule, verify that providers are Medicare enrolled, if applicable.
3.02.066	The Vendor shall prior to initial enrollment in the Medicaid program or issuance of a new provider number for an already enrolled provider for any purpose verify electronically that the provider and anyone known to be affiliated with the provider's business are not listed on the Alabama Medicaid Agency and Medicare (HHS/OIG) exclusion listings. In addition, the Vendor shall verify that a potential provider's physical or billing address, SSN, and tax ID are not associated with any of the providers on the Alabama Medicaid Agency or Medicare exclusion listings. If the Vendor determines a potential provider is on either of these lists or has any of the associations listed above, the Vendor shall not approve the application request and refer the application to Alabama Medicaid's Program Integrity Division within two (2) days of identification.
3.02.067	The Vendor shall forward to the Alabama Medicaid Program Integrity Division any application received with any type of disclosure information, whether it is on the Disclosure Page or a separate sheet contained within the application. If this information has been previously submitted on prior applications and the application was approved for enrollment by the Program Integrity Division, any subsequent applications submitted for the same provider and

New #	Provider Requirements
	containing the same and/or additional disclosure information shall still be forwarded to the Program Integrity Division. This information shall be forwarded to the Agency within two (2) days of receipt for approval.
3.02.068	The Vendor shall annually, upon publication of new licensure information, verify licensure for all in-state providers enrolled. Update the master provider file within five (5) days of receipt with appropriate end dates and deactivate all provider numbers for any providers identified as no longer being licensed or certified.
3.02.069	The Vendor shall upon receipt of certification and/or licensing information from any provider, prior to entry in the Provider Master File, verify and validate the received information with the applicable state agencies and licensing organizations in Alabama, Florida, Georgia, Mississippi, Tennessee, and other states as required to perform certification and licensure verification.
3.02.070	The Vendor shall prior to approving agreements with automated billing service vendors run a test submission on electronic and tape billings to ensure that the submission format is accepted by the Alabama MMIS.
3.02.071	The Vendor shall store all provider enrollment call center, provider representative call center, and provider assistance call center recordings in a secured area accessible by the Agency. All calls from these Call Centers shall be retained for a minimum of twelve (12) months. The Vendor shall work with the Agency to define search criteria to easily locate specific calls. The search criteria shall include, but not be limited to call date, time, phone number the call originated from, Provider name, Provider ID or call identifier, and the Call Center worker. If requested, the Vendor shall provide the Agency with a copy of the voice recording within one (1) hour of request.
3.02.072	The Vendor shall maintain a call management system or supply phone company reports of all line activities, busy signals, hang-ups, non-connects, and internal reports of number of calls answered, number of calls put on hold, and the length of time each call was held. Provide a monthly report on given statistics for the EMC hotline, provider assistance center, AVRS, and provider enrollment no later than 5th day of the following month.
3.02.073	The Vendor shall ensure all provider relations staff are trained in current billing procedures, Alabama Medicaid Program policy, and telephone inquiries. The Vendor shall provide additional training to staff no later than two (2) days prior to any billing or policy changes.
3.02.074	The Vendor shall receive, track and promptly respond to all verbal inquiries on claim status, prior authorization status, billing problems, billing procedures, Medicaid policy and remittance advices no later than the end of the next day.
3.02.075	The Vendor shall track and respond in writing to all written correspondence, including inquiries on claim status, billing problems, billing procedures, and remittance advices within five (5) days of receipt.
3.02.076	The Vendor shall maintain on-line, real-time **all** provider enrollment files and all correspondence with said provider under their correct NPI number. Currently stored in COLD.
3.02.077	The Vendor shall provide the Agency with monthly reports summarizing all calls answered, the nature of the inquiries, and the timeliness of responses to verbal inquiries and written correspondence, according to Agency specifications. The monthly report will cover the

New #	Provider Requirements
	previous month's activity and be provided no later than 5th day of the following month.
3.02.078	The Vendor shall employ sufficient staff to perform quarterly and on-request provider training responsibilities. At a minimum, provide at least thirteen (13) Medicaid-dedicated, full-time provider field representatives, one of which shall be designated as a supervisor, to provide quarterly and on-request training and to assist providers in understanding program policy, the responsibilities of managed care providers, the submission of claims and in the resolution of claims processing problems. A designated number of provider representatives shall be assigned to specific program areas by the Agency.
3.02.079	The Vendor shall maintain contact with all professional associations of health care providers in Alabama to promote provider understanding of the Alabama Medicaid Program and shall attend meetings as defined by the Agency.
3.02.080	The Vendor shall provide support, including on-site training if required, to instruct providers in using electronic claims submission software or to facilitate the resolution of billing problems.
3.02.081	The Vendor shall develop and implement a testing process for providers who wish to begin submitting electronic media claims to ensure provider compliance before allowing EMC transmission.
3.02.082	The Vendor shall employ one (1) full-time EMC coordinator and adequate staff to answer a minimum of three (3) lines; provide training; and assist providers in the submission of claims and in the resolution of claims processing problems.
3.02.083	The Vendor shall ensure that provider representatives and Provider Assistance Center staff are sensitive to provider training and inquiry needs. Provider Representatives shall be willing and able to provide on-site support to a provider whenever requested, within a reasonable period of time. Provider representatives should meet individually with designated Medicaid program staff at least monthly.
3.02.084	The Vendor shall provide a written Provider Relations Contact Form for each visit made to a Provider. The Provider Relations Contact Form will include at a minimum: - Provider Name - Provider Type - Provider Number - Provider Location - Provider Phone Number - Contact Person(s) - Visit Initiated By - Date of the Visit - Length of Visit - Description of the billing question, comments, and/or issues that were discussed during the visit - Provider Representative Signature and Name Signature Date The Vendor shall provide a monthly Summary Report of the above for the previous month's activity. The Vendor shall include the Provider Relations Contact Forms with the Summary Report and provide to the Agency no later than 5th day of the following month.
3.02.085	The Vendor shall provide a written staffing report on a monthly basis which will include

New #	Provider Requirements
	positions available, staffing updates for the following areas: - Provider Relations; - Provider Assistance Center; - Provider Enrollment; and - Recipient Call Center. The Vendor shall provide a monthly report of the above for the previous month's activity to the Agency no later than 5th day of the following month.
3.02.086	The Vendor shall develop and submit to the Agency for approval, an annual provider training plan within ten (10) days of the beginning of each contract year and within three (3) days of updating the plan as necessary.
3.02.087	The Vendor shall develop provider training materials and obtain Agency approval of the materials prior to use in the provider training programs.
3.02.088	The Vendor shall be responsible for all logistical arrangements, training materials, and space costs for provider training.
3.02.089	The Vendor shall conduct provider training for Agency-designated organizations and active providers by claim or provider type as requested by the Agency at Agency approved locations. Active Providers may request training when necessary.
3.02.090	The Vendor shall provide special in-depth training to providers who have been identified (by the Vendor, by the Agency, or the provider's association) as having an abnormal number of claims denied or suspended, repeated problems with certification or recertification, an abnormal number of problems using the Vendor's systems, underutilization of required immunizations, underutilization of EPSDT screenings and referral requirements and inappropriate patterns as reflected on provider report cards.
3.02.091	The Vendor shall develop, distribute, and evaluate training questionnaires from all training sessions, and provide the Agency with a summary of responses within five (5) days of training completion.
3.02.092	The Vendor shall write and obtain Agency approval of, print, and distribute the provider billing manual. The provider billing manual shall be available on CD-ROM. Copies shall be sent to all providers, all provider associations, the Agency, and other entities specified by the Agency, with the number of copies determined by the Agency. The Vendor shall update the provider billing manual on an as-needed or Agency-requested basis. The Vendor shall mail provider billing manual and updates (CDs and paper copies) within twenty (20) days of approval by the Agency.
3.02.093	Semi-annually, with dates to be approved by the Agency, the Vendor shall produce and mail an Agency approved listing of practitioner license numbers to all pharmacy providers and other Medicaid providers on CD with the Provider Manual as requested. The listing shall include the license number and physician name for all records on file.
3.02.094	The Vendor shall write and obtain Agency approval of, print, and distribute the provider bulletins and notices. Copies shall be sent to all providers, all provider associations, the Agency, and other entities specified by the Agency, with the number of copies determined by the Agency. The Vendor shall mail provider bulletins and notices within ten (10) days of

New #	Provider Requirements
	approval by the Agency.
3.02.095	The Vendor shall maintain the capability to electronically transmit/distribute as specified by the Agency all Provider Notices/Alerts that are prepared by the Agency.
3.02.096	The Vendor shall issue Agency approved provider bulletins every two (2) months to alert providers of program and/or billing changes.
3.02.097	The Vendor shall produce and mail other provider notices, in a format designated by the Agency, with bulletins, manuals, enrollment packages, or as an individual mailing as directed by the Agency. Examples would be notices other than bulletins such as letters, flyers, etc. The Vendor shall mail these notices within the timeframe designated by the Agency.
3.02.098	The Vendor shall maintain the provider billing manual in a format that facilitates updates and includes step-by-step billing instructions.
3.02.099	The Vendor shall develop, modify, print, and distribute to providers, at no charge, all non-standard claim forms, attachments and other billing documents approved by the Medicaid Program within five (5) days of receipt of the request.
3.02.100	The Vendor shall work closely with the Agency to develop and obtain approval of the provider manual and bulletin formats.
3.02.101	The Vendor shall produce data for provider audits and quality assurance within two (2) days of request.
3.02.102	The Vendor shall maintain data on Agency programs affiliations (e.g. Patient 1st, Maternity Care, and Medicare Advantage) for each provider.
3.02.103	The Vendor shall notify the Agency in writing within two (2) days of discovery of suspected provider fraud or provider billing errors resulting in overpayment.
3.02.104	The Vendor shall update the PMF within one day of notification any changes brought to the attention of the Vendor by the State, providers, or from within.
3.02.105	The Vendor shall provide on a daily basis by 7AM a provider file update report which shall cover update transactions for the previous day.
3.02.106	The Vendor shall maintain all provider records. Any delete process must receive prior approval from the Agency.
3.02.107	The Vendor shall maintain all demographic and rate information to support claims processing and reporting functions as is currently done and/or needed for NPI.
3.02.108	The Vendor shall maintain, and coordinate with Medicaid, updates to the institutional rates on the Provider Master File.
3.02.109	The Vendor shall maintain a cross-reference of Medicaid-Medicare provider numbers to support crossover claims processing.
3.02.110	The Vendor shall perform quality assurance of data in the PMF and submit results to the Agency on a monthly basis by the 5th of the Month.
3.02.111	The Vendor shall utilize the websites, yellow pages, and phone calls to verify the accuracy of

New #	Provider Requirements
	data such as addresses and phone numbers for returned mail. The corrected information shall be updated in the PMF within five (5) days or an Agency approved timeframe.
3.02.112	The Vendor shall ensure PMF update access will be limited to designated personnel.
3.02.113	The Vendor shall provide on-line, real-time edits to verify accuracy of provider data as entered on panels.
3.02.114	The Vendor shall maintain a 99.8% accuracy rate for processing provider applications and entering information into the system. 99.8% accuracy applies to the following data fields: - All Provider Names - Provider ID (NPI) - Provider Addresses (All to include city, county, state, 9-digit zip code, service location, pay to, mail to and home office) - Telephone/Fax Numbers - License Number - SSN - CLIA Number - Contract effective and end dates - Primary Contact name If the accuracy rate falls below 99.8%. The Vendor shall develop and submit to the Agency for approval a performance improvement plan within five (5) days of notification of deficiency. The plan must be implemented within five (5) days of approval by the Agency. If the plan does not correct the deficiency within three (3) months a revised plan must be submitted and approved.
3.02.115	The Vendor shall identify and maintain all categories of service and specialties that a provider is allowed to bill, including effective dates.
3.02.116	The Vendor shall maintain and update monthly the Patient 1st PMP lists by county on the Alabama Medicaid website. The PMP list should include Provider Specialty, Provider Name, May Also See (if applicable), Provider Service Location, Office Phone Number, After Hours Phone Number, and Fax Number. This list shall be provided to the Agency for posting on the website by the 15th of the month.
3.02.117	The Vendor shall provide an on-line user manual to instruct Agency staff on accessing the Provider subsystem. The Vendor shall maintain the on-line user manual to reflect current system functions. The Vendor shall provide hands-on user training for a minimum of twenty-four (24) Agency staff monthly or as requested by the Agency.
3.02.118	Prior to enrollment the Vendor shall verify through on-site visits that durable medical equipment (DME) provider applicants have fully functional locations and meet the requirements specified in the Alabama Medicaid Administrative Code Chapter 13 and the Provider Billing Manual.
3.02.119	The Vendor shall establish provider end date for home health and durable medical equipment (DME) enrollees as the date their current business license expires. The Vendor shall conduct re-enrollment prior to license expiration and in accordance with initial enrollment process.
3.02.120	The Vendor shall conduct re-enrollment of all providers, except home health and DME, every five (5) years. The Provider re-enrollment shall include Patient 1st re-enrollment. The initial

New #	Provider Requirements
	re-enrollment shall occur during the first year of operations.
3.02.121	The Vendor shall provide staffing levels for the PAC and EMC to achieve an average of two and a half minute or less hold time with an 8.5% or less abandonment rate after fifteen (15) seconds. Therefore, an answer rate of 91.5% or greater has been targeted.
3.02.122	The Vendor shall use USPS approved software to convert the Provider mail to address in the PMF to conform with standardized USPS regulations. This includes adding Zip + 4.
3.02.123	The Vendor shall develop a secured web application that allows Providers to submit all required information on the enrollment/re-enrollment applications and make Agency defined changes to the Provider's information.
3.02.124	The Vendor's provider web application shall allow the Providers to update selected information. The Vendor shall work with the Agency to identify the information Providers are allowed to update. The information Providers are allowed to update through the web application will not require a provider signature page.
3.02.125	The Vendor shall define a process to report statistics associated with the provider web portal. The process and statistics reported must be approved by the Agency. The statistics will include but not be limited to the performance measures, provider usage and application errors associated with the provider web application.
3.02.126	The Vendor's provider web application will edit the provider application entry and update fields for presence, validity and formatting when possible. The field validation will use data that is maintained in the AMMIS and return applicable error messages on-line real-time. Enrollment information that is not maintained in the AMMIS shall be validated and a response returned to the Provider within five (5) days of entry. Update information that is determined to be incorrect or in error shall be returned to the Provider within two (2) days of entry.
3.02.127	The Vendor's provider web application shall validate the Provider mailing and physical (service location) addresses using USPS approved software. The zip + 4 will be validated if entered or added at time of entry if not supplied by the Provider.
3.02.128	The Vendor's provider web application shall use the Managed Care defined process to identify or validate the Provider county based on the service location.
3.02.129	The Vendor shall capture all information entered in the Provider web portal. The information shall be stored in the Provider Master File or another location approved by the Agency.
3.02.130	The Vendor's provider web application shall provide the capability to print the entire application form with the information entered by the Provider. The Provider will be informed that they must print and sign specified signature pages. These signature pages and any other documents requested shall be mailed to the address indicated and received by the Vendor within ten (10) days of entry.
3.02.131	The Vendor's provider web application shall create a facsimile in the electronic document database for every electronically submitted enrollment application or update. The Vendor shall assign tracking numbers to all facsimiles. The Vendor shall store the documents in a method that allows for search by Provider name and Provider number, if assigned.
3.02.132	The Vendor shall develop a plan to educate the providers on the new web based enrollment and update application. The Provider education plan shall be submitted to the Agency for approval. The Vendor shall begin implementing the Agency approved Provider education

New #	Provider Requirements
	plan within an Agency approved time frame.
3.02.133	The Vendor's Provider enrollment staff shall support all Provider inquiries on the Provider enrollment and update web application.
3.02.134	The Vendor shall provide on a monthly basis operational reports from the provider enrollment staff, provider representative staff, and provider assistance center about the types of inquiries received during the month, by hour segment and day. The monthly reports shall cover the previous month's activity and be provided no later than the 5th day of the month. The Vendor shall work with the Agency to define the types of inquiries to be tracked.
3.02.135	The Vendor shall maintain and staff a provider communications/relations inquiry function to include toll-free lines. Adequate staff will be provided to answer a minimum of sixteen (16) toll-free telephone lines concurrently with the capacity of up to forty (40) lines from 8:00 AM to 5:00 PM local time, Monday through Friday (excluding State-observed holidays). If the Agency requires more than sixteen (16) lines to be staffed reimbursement will be made in accordance with Section 6 - General Terms and Conditions of this ITB.

3.03 Recipient Requirements

The Medicaid Agency maintains the Recipient Subsystem. The primary component of the Recipient Subsystem is known as the Alabama Medicaid Application and Eligibility System (AMAES). The AMAES has consisted of Virtual Sequential Access Method (VSAM) files since 1984. The AMAES Recipient Subsystem supports Beneficiary Services and eligibility functions; Third Party Liability and Buy-In, Non-Emergency Transportation; and Program Integrity as well as supports interfaces with other state and federal organizations including the Department of Human Resources, Department of Public Health, State Data Exchange, IRS, and others.

The primary purpose of the AMMIS functions is to accept and maintain an accurate, current, and historical source of eligibility and demographic information on individuals eligible for medical assistance, and to support analysis of the data contained within the Recipient Subsystem. The maintenance of recipient data is required to support claim processing in both batch and online mode, reporting functions, eligibility verification, and information retrieval systems.

The Medicaid Recipient Subsystem involves processing and maintaining recipient specific information needed for claims processing and reporting. The system needs to provide recipient information so that the Claims subsystem can determine whether a service is covered for a specific recipient based upon Alabama Medicaid policy. The Recipient subsystem also needs to maintain certain recipient information to create management reports that help drive Alabama Medicaid policy and ensure adequate levels of medical care for the recipient population.

Maintenance of recipient related data is also described in other functional sections such as TPL, LTC, and Managed Care. The current source of eligibility data for the AMMIS is a daily file extract from the Recipient Subsystem.

The following are the requirements identified by the Agency that must be met by the Vendor to support the successful operation of the Recipient Data Maintenance functions.

New #	Recipient Requirements
3.03.001	The Vendor shall maintain recipient data as a part of the AMMIS including eligibility timeframes for full and limited eligibility benefit plans groups. The Vendor shall receive nightly, monthly, annually and other periodic updates to recipient information from the Agency. The data must be applied to the Vendor's recipient data by 6:00 AM the morning after the transmittal. There shall be control and reconciliation reports that are approved by the Agency and monitored by the Vendor. The Vendor shall notify the Agency of any errors that occur. The Updates shall include but not be limited to: Plastic card requests, patient liability data, retroactive eligibility data and county moves data.
3.03.002	The Vendor shall link nursing home provider information to the recipient so that changes to the name and address on the nursing home provider file are updated in the recipient's information.
3.03.003	The Vendor shall perform automated processes related to recipient participation in managed care, including but not limited to auto assignment, maintenance of capitation payments, roster generation, and data updates.
3.03.004	The Vendor shall provide an interactive interface or electronic media transfer of transactions with the managed care health plans for search and updating of specified recipient data, such as managed care health plan enrollment.
3.03.005	The Vendor shall provide an interactive interface or electronic media transfer that allows the primary medical provider to view or download the updates of primary medical provider assignments and capitation payment information.
3.03.006	The Vendor shall maintain all data elements necessary to support the generation of health plan rosters, capitation payment processing, and other managed care functions, and assure eligibility certification agreement to procedures adopted.
3.03.007	The Vendor shall maintain at least sixty (60) days of recipient data transmissions received from the Agency in case of system problems.
3.03.008	The Vendor shall maintain a data base of current recipient eligibility data, including TPL and Managed Care with daily updates of recipient data from the Agency. This information shall be used for FFS and encounter claims processing to ensure that the most current recipient data is used for correct payment.
3.03.009	The Vendor shall generate and deliver to Medicaid or store all recipient reports identified on the Alabama MMIS Reports Listing located in the Procurement Library.
3.03.010	The Vendor shall provide capability for meeting ANSI ASC X12 (HIPAA) 5010 electronic data interchange transaction sets for eligibility transactions and plan enrollments as they become available.
3.03.011	The Vendor shall maintain a data base of current recipient eligibility data; including TPL and Managed Care with daily updates of recipient data from the Agency, to support provider inquiry and billing (e.g., automated voice response, dial-up eligibility verification inquiries, electronic transactions, web or point of service inquiries.
3.03.012	The Vendor shall notify the Agency in writing, with documentation, of suspected recipient, provider, employee or sub-contractor fraud within twenty-four (24) hours of identification of the fraud.

New #	Recipient Requirements
3.03.013	The Vendor shall make recommendations yearly on any area of improvement in Agency or fiscal agent activities in the current system. These recommendations must be in writing and presented in person to the agency before the end of the first quarter of the calendar year.
3.03.014	The Vendor shall produce new and replacement plastic magnetic stripe identification cards and mail them to the recipient. The magnetic stripe shall contain the recipient name and ID number. There shall be a number on the card to define the number of times the card has been issued. The original card shall start with 00 and it shall increment by one (1) for each additional card issued. New or replacement cards shall be produced within forty-eight (48) hours of the request and mailed to the recipient within three (3) days of receipt of the request. There is an average of 23,000 new and replacement cards produced a month. The Vendor shall issue replacement cards in accordance with current Agency policy.
3.03.015	The Vendor or their sub-contractor shall ensure there is a secure card production environment with secured vault storage of card stock. The Vendor shall provide written documentation of the process, a mock up of the card and a copy of the security agreement to the Agency for approval prior to the production of the first cards. The Vendor shall notify the Agency in writing (with a mock up of the card) thirty (30) days before any modification in the process or the security agreement can be implemented. Once the Agency approves the changes the Vendor has thirty (30) days to update the written documentation.
3.03.016	The Vendor shall maintain and provide maintenance for a dedicated T1 communication line between the State Data Center in the Capitol Complex and the Vendor's computer for data transmissions using Connect:Direct File Transfer or a SFTP (Secure File Transfer Protocol) solution. The data exchanges can occur daily, weekly, monthly, etc. and they include but are not limited to eligibility (adds, changes), provider, DSS, reconciliation, claims, checkwrite, and MSIS.
3.03.017	The Vendor shall maintain a minimum of seventy-two (72) months of all recipient and eligibility data on-line and in DSS starting with the most current seventy-two (72) months. The Vendor shall provide search capability by recipient ID number, payee or case number, Medicare number, name or partial name, social security number, and the ability to use other factors such as date of birth to further refine the search by criteria.
3.03.018	The Vendor must notify the Agency of critical operational or system problems (problems that prevent recipient eligibility verification or claims payment) and discrepancies resulting from the recipient update process. The next day the Vendor shall provide written documentation of the problem, the solution and a time or estimated time of completion.
3.03.019	The Vendor shall monitor the eligibility process and notify the Agency weekly of non-critical operational or system problems. The Vendor shall provide written documentation of the eligibility errors, process resolution and a time or estimated time of completion. The Vendor shall receive approval from the Agency before taking any action.
3.03.020	The Vendor shall maintain an on-line real-time panel that allows the Agency to search and/or update recipient data, including but not limited to partial eligibility, full eligibility, recipients with no eligibility (head of household/payees only), denied cases, pending cases, restriction/lock-in data, LTC data, financial application data and patient liability information with effective dates.
3.03.021	The Vendor shall provide a report of lock-in recipients whose eligibility status has changed monthly on the first day after the recipient monthly updates occur.

New #	Recipient Requirements
3.03.022	The Vendor shall maintain a recipient system that interfaces or shares data with other vendor subsystems such as TPL, LTC, EPSDT, Managed Care, etc.
3.03.023	The Vendor shall accept and process on-line, real-time updates to MMIS recipient data, lock-in data and LTC Data. The Vendor shall provide documentation on the update process and returning the updated information to the Agency. The process shall be approved by the Agency prior to going production.
3.03.024	The Vendor shall maintain the minimum data prescribed by Part 11 of the State Medicaid Manual.
3.03.025	The Vendor shall maintain birth date fields that distinguish recipients who are over one hundred (100) years old from recipients who are infants or children. The century must be maintained for all birthdates.
3.03.026	The Vendor shall allow for future birthdates. This will be used for unborn children. For claims payment the unborn Medicaid id or the mothers Medicaid ID may be used.
3.03.027	The Vendor shall capture retroactive eligibility segments with benefit Plan, issue date, start date and end date to ensure proper subsequent capitation payment, billing, premium billing, claims payment, etc. The yearly filing limit for retroactive eligibility shall be based on the issue date rather than the eligibility start date.
3.03.028	The Vendor shall send a nightly update to the Agency that contains LTC, Managed Care, EPSDT, Good Cause Indicator and any other recipient data that is maintained by the Vendor but must be used by the Agency. This file shall be sent to the Agency by 6:00 AM.
3.03.029	The Vendor shall maintain current and historical date-specific eligibility data for Medicare/Buy-In coverage and other recipient data required to support all MMIS functions.
3.03.030	The Vendor shall maintain recipient subsystem updates from all external sources with an audit trail that indicates the data that changed and the source of the update.
3.03.031	The Vendor shall accommodate on the lock-in panel multiple pharmacy segments with the same or overlapping start and end dates with the same or different prescriber license numbers.
3.03.032	The Vendor shall maintain and cross-reference changes in social security numbers, case ID numbers and Medicaid numbers. The Vendor shall not use the social security number for claim payment. The case ID (payee) number must link all Medicaid numbers in a household.
3.03.033	The Vendor shall maintain a process to move a recipient's claims history from one Medicaid number to another number as designated by the Agency. The Vendor shall maintain panels that allow selected Agency personnel to move claims from one Medicaid number to another on-line real-time. There shall also be a batch process that will be available to move large quantities of claims for recipients.
3.03.034	The Vendor shall accommodate Medicaid identification number made up of thirteen (13) digits (at a minimum) the number will be supplied by the Agency. The Medicaid ID number is comprised of a twelve (12) digit number with a check digit. The check digit is required for any inquiries or transmissions by the provider.

New #	Recipient Requirements
3.03.035	The system shall have table driven option Maintain flexibility in coding structures, such as recipient aid categories and program identifiers, to support changes to claims processing and reporting requirements.
3.03.036	The Vendor shall identify potential duplicate recipient records during update processing and in special batch processing. The vendor shall produce a report daily by 7:00 AM and the report shall be stored in COLD.
3.03.037	The Vendor shall create and transmit eligibility and TPL file extracts for use in automated data matches with private insurance carriers and state, city, county and federal agencies as requested by the Agencies.
3.03.038	The Vendor shall create Medicaid eligibility extracts for Medicare according to the CMS schedule. The file shall be transmitted or uploaded to Medicare per their specifications. The extracts shall include Medicaid recipients with current eligibility or recipients whose eligibility has been terminated within the past twelve months and recipients with current Medicare coverage. The extract shall include all recipients with Medicare Part A, Part B and Part B-DMERC. The data in the extract shall contain the data required by Medicare and be in the format defined by Medicare.
3.03.039	The Vendor shall produce recipient error listings of update transactions daily.
3.03.040	The Vendor shall apply the buy-in data from all AMAES updates and the data from the Medicare Electronic Data Base (EDB) file using an Agency defined process. The Agency defined process identifies the criteria the Vendor shall use to define the Medicare A & B coverage segments including Medicare ID, start and end dates.
3.03.041	The Vendor shall utilize the Medicare A or B segments for processing Medicare Part D claims. The start and end dates for Part A or Part B segments shall also be used for Part D coverage.
3.03.042	The Vendor shall have a panel that displays the Medicaid ID numbers for all family members. The case number or payee number shall be used to access the information.
3.03.043	The Vendor shall maintain a process to merge (link) recipients with more than one record. The Vendor shall also maintain a process to unmerge (un-link) two or more recipients that have been merged in error. The merges may be sent as part of the nightly update files or a request by e-mail.
3.03.044	The Vendor shall not allow a recipient to be assigned to a provider who is inactive.
3.03.045	The Vendor shall maintain Recipient, Pharmacy & Provider Lock-in data and panels. The MMIS shall accept on-line real-time updates to the lock-in panels.
3.03.046	The Vendor shall provide the recipient, physician and pharmacy lock-in data in DSS as requested by the Agency.

New #	Recipient Requirements
3.03.047	The Vendor shall maintain a process to generate recipient claim history requests and show all claims, adjustments, and financial transactions that have occurred for the selection parameters requested. The process shall access all claims history and all claim types. The reports shall be produced within one (1) day of the request and shall be printed on single-sided paper and delivered to the Agency in the standard mail run. Due to the one day turn-around requirement, the reports shall be produced from the MMIS (DSS is not updated nightly). The reports shall be produced by recipient (including merged recipient ID numbers) not claim type. The report shall include a description of procedure, drug, diagnosis, error codes and provider name.
3.03.048	The Vendor shall provide on-line real-time add/update capability to selected data fields on the Medicare Coverage Panels by a limited number of designated Agency staff.
3.03.049	The Vendor shall accept LTC applications from the LTC Notification Software. The eligibility of the applicant shall be verified using the AMAES Recipient information that is transmitted to the vendor nightly.
3.03.050	The Vendor shall create and transmit a monthly recipient reconciliation file on a schedule defined by the Agency. The Agency will use the vendors file to verify the recipient updates were made correctly.
3.03.051	The Vendor shall maintain the original Medicaid id for each recipient. There shall also be a recipient cross reference file that maintains the history of all Medicaid ID's assigned to a recipient.
3.03.052	The Vendor shall process changes in Medicaid ID's for recipients. These changes will be included in the nightly, monthly and Annual updates. The vendor shall link a recipient's data when it is indicated on the file or unlink the recipient's data. This includes changes across all subsystems including but not limited to: Claims, TPL, LTC, PA and Managed Care. The process shall be defined, documented and approved by the Agency.
3.03.053	The Vendor shall make manual changes to recipient data as requested by the Agency. The changes shall be made in two (2) days of the request. This includes but is not limited to recipient social security number, county number and date of birth.
3.03.054	The Vendor shall allow a pharmacy lock-in segment for controlled drugs (or any other medications identified by the Agency) to be assigned to a recipient with a valid prescriber license number or no prescriber license numbers. If the segment contains a valid license number the recipient shall be eligible to receive controlled substances (or any other medications identified by the segment). If the segment does not contain a prescriber license number it will prevent the recipient from receiving any controlled substances (or any other medications identified by the segment).
3.03.055	The Vendor shall allow lock-in segments to be entered on recipients regardless of their current eligibility status.
3.03.056	The Vendor shall provide the ability to create provider dummy number to be used for lock-in assignment to the recipient. This shall prevent recipient lock-in claims from paying before the recipient is actually assigned a lock-in provider. This must be available when the system goes live.

New #	Recipient Requirements
3.03.057	The Vendor shall provide the ability to create pharmacy dummy number to be used for lock-in assignment to the recipient. This shall prevent recipient lock-in claims from paying before the recipient is actually assigned a lock-in pharmacy. This must be available when the system goes live.
3.03.058	The Vendor shall allow multiple lock-in segments for a recipient. Each segment shall have a start date, end date and provider ID.
3.03.059	The Vendor shall maintain an audit trail of all changes to lock-in data. This audit trail shall include but not be limited to before and after field values, user id and date/time stamp.
3.03.060	The Vendor shall create and maintain a list(s) of non-controlled drugs identified by the Agency. The Agency shall notify the Vendor of any new list or any drugs to be added to an existing list.
3.03.061	The Vendor shall create and maintain a list of controlled drugs. The list shall be included in standard updates such as but not limited to the drug data warehouse vendor updates.
3.03.062	The Vendor shall have recipient eligibility inquiry that allows the provider to input the parent's (payee/case) Medicaid ID and the date of birth of the child in the household for which you want to obtain the Recipient Medicaid ID number. The search result shall return the Medicaid ID and information for that specific child.
3.03.063	The Vendor shall produce a monthly report of recipients that have exceeded their benefit limits during the current year. There shall be another report that identifies recipients that have exceeded their benefit limits during the previous year. Recipients may exceed their benefit limits due to system errors and/or forced claims. These reports are to be produced monthly after the last checkwrite of the month and will be available in COLD the first day after the last check write of the month.
3.03.064	The Vendor shall maintain a call center with a toll free number for recipient calls. The Vendor shall also have a dedicated toll free number for TDD/TYY equipment.
3.03.065	The Vendor's Call Center shall process phone request on-line and real-time at the time of the call. The paper request will require a paper response. The system updates shall occur within one day of the receipt of the request. The return response shall be mailed within two (2) days of receipt of the request.
3.03.066	The Vendor's call center shall process the following request: * Patient 1st forms (Form 349) * Patient 1st county codes reassignments * Patient 1st exemptions * Patient 1st doctor assignment requests * Removal of Medicare recipients assigned to Patient 1st.
3.03.067	The Vendor shall respond to inquires or discuss the following information with recipients: * Claim status all Medicaid programs * Medicaid coverage information for prescription drugs based on a NDC lookup * Program eligibility verification for recipients (inquiries from recipients or providers).
3.03.068	At the time of the call, the Vendor shall provide basic recipient eligibility assistance and answer questions for all aid category groups including eligibility requirements and how and where to apply.

New #	Recipient Requirements
3.03.069	The Vendor shall accept and resolve calls from recipients related to eligibility inquires including but not limited to: descriptions of appropriate types of citizenship and identity forms and assistance with helping callers find out how to get the documents.
3.03.070	The Vendor shall provide application status (pending=P; awarded =A; denied=D; and terminated =T) to applicants. For pending cases (if application was received less than forty-five (45) days from the date of the call, the Call Center Representative shall check the file to see if the application shows up in the system as pending. If so, respond that the case is pending. If it does not show up in the system, respond that Medicaid has forty-five (45) days to process a case and the application may not have been entered into the system yet. Advise them to check back in 7-10 days. If the application was received more than forty-five (45) days from the date of the call, then refer to the assigned caseworker using the caseworker file to look up the workers name and phone number. For denied cases then refer to the assigned caseworker using the caseworker file to look up the worker's name and phone number. For terminated cases instruct the individual to complete another application [mail the appropriate applications to the individual and/or direct them to the web application]).
3.03.071	The Vendor shall discuss benefit limits for all programs.
3.03.072	The Vendor shall answer policy questions about claims for all programs.
3.03.073	The Vendor shall initiate Non-Emergency Transportation (NET) vouchers requests. The following information will be captured during the intake process and passed to the NET office: * Date of Request * Requester's Name * Requester's Relationship * Requester's Phone Number * Recipient Number * Recipient Name * Recipient Date of Birth * Recipient Address * Recipient Phone Number * Recipient Information on file * Recipient's Doctor * Doctor's Address * Doctor's Phone Number * Appointment Date * Appointment Time * Reason for Appointment * Mode of Transport * If recipient is confined to a wheelchair * Diagnostic reason for wheelchair bound * If special transportation assistance is required.
3.03.074	The Vendor shall transfer recipient calls to the NET office for follow up on previously requested vouchers.
3.03.075	The Vendor shall refer all calls pertaining to the Medicare Part D program or Low Income Subsidy Program to either the Social Security Administration (SSA) or the local Area Agencies on Aging.

New #	Recipient Requirements
3.03.076	The Vendor call center phone request include: * Patient 1st doctor assignment requests * Replacement Medicaid card requests for recipients from the Agency, SOBRA workers, or Medicaid Recipients * Requests for temporary Medicaid cards * Respond to providers request for eligibility verification by fax or phone.
3.03.077	The Vendor shall update eligibility file change requests received via phone and/or web application to change name, address, sex code, phone number, county code, marital status, and/or race for MLIF, SOBRA, and Plan First certified cases.
3.03.078	The Vendor shall update the eligibility file change requests received via phone and/or web application to change address, phone number, and marital status of the beneficiary and update sponsor's address and phone number for District Office (Elderly & Disabled) certified cases. For marital status changes, the spouse's name, address, SSN & DOB must be verified.
3.03.079	The Vendor shall notify the assigned Agency worker of a requested change when an error message is returned after attempting to update the eligibility file. The call center representative shall capture supporting documentation such as screen prints, data entered and any other data requested by the Agency. The supporting documentation shall be sent to the assigned Agency worker within one (1) day.
3.03.080	The Vendor shall screen calls for District Offices and Family Certification workers by answering eligibility questions for various Medicaid eligibility programs. These include: * Nursing Home eligibility * ICF/MR eligibility * HCBS eligibility * Post extended hospital care eligibility * Medicare Savings Programs (QMB, SLMB, QI1, QDWI) eligibility * SSI cases such as Disabled Adult Child (DACs), Retroactive SSI, PICKLE, widow/widower eligibility * Pregnant women and children (SOBRA Medicaid) * Medicaid for Low Income Families.
3.03.081	The Vendor shall receive, log, and file returned Medicaid cards that failed to be delivered to the recipient.
3.03.082	The Vendor shall keep all returned Medicaid cards in a secure location such as a locked file cabinet or safe for six (6) months in case the recipient calls for the card. After six (6) months the Vendor shall destroy the card in a chipper style shredder and discard in the trash.
3.03.083	The Vendor shall refer recipients to apply online at www.insurealabama.org for SOBRA/MLIF Medicaid, ALL KIDS, and Alabama Child Caring Programs when the recipient has access to the Web. The Vendor shall answer questions about the web applications and requirements.
3.03.084	The Vendor shall transfer the call to the assigned caseworker at the District Office, if the call pertains to a case that has been awarded, pended, is in progress, or has been denied.

New #	Recipient Requirements
3.03.085	The Vendor's shall address policy questions for the following programs: * Nursing Homes * Hospice * Home Health * DME * Private Duty Nursing Program * ICF/MR Facilities * Elderly and Disabled Waiver * Living at Home Waiver * Mentally Retarded Waiver * State of Alabama Independent Living Waiver (SAIL) * Technology Assisted Waiver for Adults (TA) * AIDS Waiver * MR/DD Waiver.
3.03.086	Before and after business hours, the Vendor shall have all units: * Listen to Frequently Asked Questions recordings * Check claim Status using interactive menus * Check Medicaid eligibility using interactive menus.
3.03.087	The Vendor shall supply a phone system that routes calls to representatives based on responses to the prompts played to the caller. The caller will be able to select one of 8 different paths as listed in Requirements 3.03.088 - 3.03.95.
3.03.088	The Vendor shall have the AVRS selection 1 as Automated Claims Status and Verification of Coverage. Recipients shall be able to call twenty-one (21) hours per day, seven (7) days per week, to hear the status of a claim or to verify Medicaid coverage via the Automated Voice Response System. The caller shall be prompted to enter key information such as the recipient number using a touch-tone phone to retrieve the information from the system. Routine maintenance shall be scheduled between 2AM and 5AM daily. The Vendor shall implement a redundant automatic voice response system (AVRS). This Vendor shall provide two (2) AVRS systems which shall provide redundancy and support the current Provider AVRS and the new Recipient Call Center AVRS. Each AVRS shall operate concurrently, sharing the load. Should one of the two systems fail, the other shall support both the Provider AVRS and the Recipient Call Center system until service can be restored.
3.03.089	The Vendor shall have the AVRS selection 2 as Application Requests. Recipients and potential applicants shall be able to call twenty-four (24) hours per day, seven (7) days per week, to request an application for a Medicaid program. By making touch-tone responses to the telephone system prompts, callers shall be directed to one of four voice mail boxes where they shall be able to leave their name, address, city, state, and zip code. Recipient Call Center staff members shall collect the information from these mailboxes and send the applications to the requesting party.

New #	Recipient Requirements
3.03.090	The Vendor shall have the AVRS selection 3 as Frequently Asked Questions. Recipients and potential applicants shall be able to call twenty-four (24) hours per day, seven (7) days per week, to hear responses to Frequently Asked Questions (FAQ). By making touch tone responses to the telephone system prompts, callers shall be able to navigate through the FAQ menu to hear information provided by the Medicaid Agency to the recipient community.
3.03.091	The Vendor shall have the AVRS selection 4 as Report Fraud Recording Recipients who choose this menu option shall hear a recording directing them to immediately call the Medicaid Fraud Hot-Line number at 1-866-452-4930.
3.03.092	The Vendor shall have the AVRS selection 5 as Recipient Inquiry Unit The majority of calls to the Recipient Inquiry Unit currently are related to the Patient 1st program. The calls received shall include replacement ID card requests, temporary ID card requests, program application requests, and eligibility file error correction requests. SOBRA workers may contact the RCC to request the replacement of recipient Medicaid card requests via mail, phone, or fax.
3.03.093	The Vendor shall have the AVRS selection 6 as Customer Service Unit. The Customer Service Unit shall answer a wide variety of questions. Call Center Representatives shall verify and update multiple data elements on the Recipient Eligibility Master File. They shall answer eligibility, policy, benefit, and claim status questions. In addition, they will perform the initial intake process for the Agency's NET unit. Basic information shall be obtained regarding the callers' transportation request and the request will be electronically routed to the Agency NET Unit for follow-up.
3.03.094	The Vendor shall have the AVRS selection 7 as Long Term Care (LTC) Unit. The Vendor staff in the Long Term Care unit shall be thoroughly familiar with LTC policies and procedures. They shall be trained and prepared to answer in-depth eligibility and policy questions.
3.03.095	The Vendor shall have the AVRS selection 8 as E-Mail or Fax directly to Recipient Call Center. A single e-mail address shall be provided to allow recipients to send their question or request directly to the call center. Call center representatives shall be assigned to monitor the inbox and respond to the recipient using secure email methods if PHI is included in the text of the message. Recipients may also fax a question or request to the call center. Call center representatives shall be able to fax a response to the sender if requested.
3.03.096	The Vendor shall supply a phone system that can be utilized to perform Quality Assurance functions. Calls may be recorded on-demand or based upon a specific call monitoring schedule. The intent is to routinely monitor/record calls to measure the performance of our Call Center Representatives. Calls shall be randomly monitored for all Call Center Representatives. Monitoring frequency shall be increased for any representative that exceeds a pre-set error threshold. The representatives shall be rated on the following skills: * Did the representative follow the call center etiquette procedures? * Did the representative identify themselves to the caller?

New #	Recipient Requirements
	* Did the representative follow call center handling policies? * Did the representative listen and probe effectively? * Did the representative utilize research materials appropriately (e.g., AMMIS screens, Resolutions manuals) * Did the representative read and interpret records accurately? * Did the representative exhibit courtesy and empathy? * Did the representative use good grammar and speak clearly? * Did the representative close the call correctly by verifying the action taken and explaining any follow-up activities? Any call that was not handled correctly shall be reviewed with the representative.
3.03.097	The Vendor shall operate the RCC from 8 AM to 4:30 PM, Monday through Friday, on standard Vendor business working days. The call center will remain staffed until 5 PM to answer the calls remaining in the queue. The Vendor shall transfer calls to the Agency Central Office or District Offices in accordance with the Recipient Call Center Operations Manual.
3.03.098	The inbound toll-free and outbound long distance phone expenses will be captured for rebilling to the Agency as a pass-through expense.
3.03.099	The outbound mail expenses will be captured for rebilling to the Agency as a pass through expense. Any costs incurred for mailings that require an outside mailing vendor will be passed through to the Agency.
3.03.100	The Vendor shall access the Agency's multi lingual interpreter service contract currently in use to acquire interpreter service for foreign languages other than Spanish. The Vendor shall provide a minimum of three (3) bi-lingual (English/Spanish) representatives to assist Spanish speaking clients in completing Medicaid applications, renewals and changes. All requirements for providing live assistance to recipients shall be met regardless of the language spoken by the caller.
3.03.101	The Vendor shall establish four (4) voice mail boxes for Medicaid Program application. The Vendor shall not require a Medicaid number or Social Security Number to be entered in order to request an application. The Vendor shall establish mail boxes for requests as follows: 1. Form 204/204 - Nursing Home, ICF/MR, Home and Community Based Waiver, and SSI Related 2. Form 211 – Application for Medicare Savings for Qualified Beneficiaries, ALL Kids, the Alabama Child Caring Foundation. 3. Form 291 and 291B-S - SOBRA Medicaid and Medicaid for Low Income Families (MLIF) and the Spanish version used to apply for SOBRA, ALL Kids, or the Alabama Child Caring Plan 4. Form 357 - Plan 1st (Family Planning Wavier)
3.03.102	The Vendor shall not allow recipients access to RCC staff voice boxes to leave messages for callbacks.
3.03.103	The Vendor's RCC staff shall have update and inquiry capabilities to the necessary Agency on-line screens or the Agency will be willing to make the necessary modifications to allow for data transfer.

New #	Recipient Requirements
3.03.104	The Vendor shall process Form 349 (Patient 1st). The Vendor shall shred paper copies of the form when processing is complete. The Vendor shall delete electronic forms from storage when processing is complete.
3.03.105	The Vendor shall use Agency provided program paper applications necessary for meeting the recipient's requests.
3.03.106	The Vendor shall use Agency provided envelopes for mailing applications and Medicaid cards to recipients.
3.03.107	The Vendor shall provide two locking filing cabinets for the storage of returned Medicaid cards.
3.03.108	The Vendor will transfer District Office calls to the local phone number of the District Office. The cost of the call will be captured and re-billed as with any transferred call. If at any point in the future, the Agency provides toll free numbers at each District Office, the Vendor will transfer the call to the toll free number at the Agency's request.
3.03.109	The Vendor shall accept calls from recipients making the initial request for non-emergency transportation which would result in the submission of a NET request form. The Vendor shall answer calls that can be resolved by checking the Agency's NET system screens such as confirming that a voucher has been issued.
3.03.110	The Vendor shall provide staffing levels for the RCC to achieve a one and a half minute or less hold time with an 8.5% or less abandonment rate after fifteen (15) seconds. Therefore, an answer rate of 91.5% or greater has been targeted.
3.03.111	The Vendor shall submit form using Forms iQ and Feith Workflow for the purpose of communicating to the Agency calls that require Agency intervention from the NET unit. This form will be for changes or cancellations to previously requested vouchers or the reporting of lost vouchers.
3.03.112	The Vendor shall provide before and after screen shots for eligibility file updates. These screens shots shall be sent to the Agency on a daily basis.
3.03.113	The Vendor shall process Patient 1st exemptions received in writing, by mail or fax, from an institution, group home or Department of Human Resources (DHR). The Vendor shall retain written notices for one year, then shredded for disposal.
3.03.114	The Vendor shall accept reports of birth from parents, hospitals, or providers by phone or fax and update the AMAES system.
3.03.115	The Vendor shall perform quality assurance on the phone system prompts to verify the caller can reach their desired destination. The Vendor shall develop a QA plan that will be approved by the Agency. The plan shall include scenarios to be tested and a monthly report on the QA tasks, results and changes. The Vendor shall investigate any complaints by the recipients concerning problems with the telephone prompts. The complaint, the results of the investigation and any changes made shall be included in the monthly QA report. The Vendor shall also test all paths for the phone system prompts any time a change is made to the prompts. The paths tested and the results of the test will be included in the monthly QA report.
3.03.116	The Vendor shall provide an Alabama Medicaid Interactive Web Site which requires an entry

New #	Recipient Requirements
	of the Recipient ID and their Date of Birth to access a Recipient's data.
3.03.117	The Vendor shall provide an Alabama Medicaid Interactive Web Site which allows Recipients the option to report changes via the web. The recipient web application shall allow the recipient to print an Agency approved change form and provide a Vendor e-mail, a Vendor fax number and a Vendor mailing address for form submission. The Vendor shall update the AMAES application within one (1) day of receipt of the change from the web, fax, e-mail or mail. This applies to updates referenced in Requirements 3.03.077, 3.03.078, 3.03.119, 3.03.122, & 3.03.123.
3.03.118	The Alabama Medicaid Interactive Web Site shall provide in response to the Recipient entering their Recipient ID and Date of Birth the following information: - Recipient Name - Recipient Status (Active or Inactive) - Patient 1st Doctor Name, Address and Telephone Number The Recipient status if active shall identify the "through date.
3.03.119	The Alabama Medicaid Interactive Web Site shall allow Recipients to view available Providers based on provider enrollment criteria such as but not limited to number of current patients or proximity to the Recipient's location. The Recipient shall be able to select a Patient 1st Provider from the list of available Providers. At the time of the selection, the web application shall notify the recipient of the effective date for the selected Provider.
3.03.120	The Alabama Medicaid Interactive Web Site shall allow the Recipient to request a replacement card. The Vendor shall issue replacement cards in accordance with current Agency policy. The web application shall allow recipients to print the Agency approved Medical Services Eligibility Verification (MSEV) form.
3.03.121	The Alabama Medicaid Interactive Web Site shall provide the Recipient with benefit limits used and benefits available for those services for which they are eligible. The benefit used and available shall identify the "as of date".
3.03.122	The Alabama Medicaid Interactive Web Site shall allow the recipient to submit an Agency approved change request on-line real-time. The change request shall allow the recipient to change the following information: - Address - Home Phone with Area Code - Cell Phone - E-mail Address - Marital Status - Sponsor Address - Family Changes, - Income Changes, - Expense Changes, - Insurance Changes, - Report of Death, - Ability to close a Medicaid Account or withdraw an Application, and - A free text area to enter other change information with an effective date for the change. The Vendor shall receive the information entered on the web and make the changes in the

New #	Recipient Requirements
	AMAES application within one (1) day of receipt.
3.03.123	The Vendor shall process change requests received via phone and/or web application concerning modifications to a recipient's case. These changes include: - Update the entire name, date of birth, and SSN for newborns, previously unborn. - Update screens to reflect reported changes to TPL insurance status, Request and forward a copy of the insurance card and policy to TPL. - Refer changes or questions concerning SSI cases to the appropriate Social Security Office.
3.03.124	The Vendor shall provide assistance, both via a live person and voice recorded Q & A's with zero out to a live person to potential beneficiaries who are not yet eligible and cannot access information by entering a Medicaid number.
3.03.125	The Vendor shall provide assistance to applicants with applying online or via paper application. The Vendor shall answer questions about the application and eligibility requirements.
3.03.126	The Vendor shall provide to the Agency monthly call status reports produced by the telephone system as defined by the Agency.
3.03.127	The Vendor shall provide assistance to recipients completing annual renewals.

3.04 Reference Requirements

The Reference Data Maintenance function maintains a consolidated source of reference information that is accessed by the AMMIS during performance of claims and adjustment processing functions, prior authorization functions, Third Party Liability (TPL) processing. The Reference Data Maintenance function also supports AMMIS reporting functions.

The Reference Data Maintenance function consists of the following logical data groupings:

- **Benefit Plan** - data set identifying a group of covered services (benefits) that are granted to a member who is deemed eligible for the services the benefit plan represents. Benefit Plan configuration includes:
    - Coverage Rules detailing restrictions for services within a Benefit Plan.
    - Reimbursement Rules for selecting a payment method to reimburse a Provider for services provided to an eligible member.
    - Billing Rules classifying services a Provider can bill within a contract.
- **Diagnosis** - data set utilizing the International Classification of Diseases, Ninth Revision (ICD-9) coding system and diagnosis coding.

- **Drug** - data set of eleven (11) digit National Drug Codes (NDC) including descriptive and pricing information for each code.
- **Edit/Audit Criteria** - data used to enforce Agency policy in adjudicating claims. The edit function verifies the accuracy, validity, required presence, format, consistency, allowable values, and integrity of data submitted. The audit function compares the data of a claim in process with other claim data in paid claims history to determine the appropriateness of the service reflected on the claim in relation to other services received by the member.
- **ICD-9-CM Procedure** - data set that contains International Classification of Diseases, Ninth Revision, Clinical Modification procedure codes used for inpatient hospital billing.
- **Modifier** - data set that contains codes used to further describe and qualify services provided.
- **Procedure** - data set that contains CMS Health Common Procedure Coding System (HCPCS) procedure codes, Common Procedure Terminology (CPT) procedure codes including descriptive and pricing information for each code.
- **Revenue codes** - data set for use in processing claims for hospital inpatient and outpatient services including descriptive and pricing information for each code.

The following are the requirements identified by the Agency that must be met by the Vendor to support the successful operation of the Reference Data Maintenance functions.

New #	Reference Requirements
3.04.001	The Vendor shall provide on-line real-time updates to all drug information relating to pharmacy program policy and pricing.
3.04.002	The Vendor shall maintain all data warehouse vendor fields related to drug pricing and drug information on the weekly file updates no later than Sunday with report delivery to the Agency the next business day.
3.04.003	The Vendor shall perform adhoc Reference file/database updates upon receipt of an OPR (Operations Request) from the Agency within three (3) days unless otherwise directed by the Agency.
3.04.004	The Vendor shall develop, maintain, and distribute Reference file/database update reports (electronic and paper versions) the next business day.
3.04.005	The Vendor shall review all reference file updates to ensure the integrity of data before the updates are applied for on-line and batch processes. This includes but is not limited to the prevention of adding overlapping dates, invalid dates, invalid codes, invalid benefit plan combinations, etc.
3.04.006	The Vendor shall validate and suggest, for Agency approval, prepayment and medical review criteria within one (1) day of validation.
3.04.007	The Vendor shall maintain trauma and accident indicators for identified procedures and diagnoses on-line real-time.

New #	Reference Requirements
3.04.008	The Vendor shall establish relationships between provider type and each procedure or service for which they are authorized to bill and be paid. This Information shall be available on-line real-time.
3.04.009	The Vendor shall provide on-line real-time search capability to identify all procedure codes within a Provider Contract.
3.04.010	The Vendor shall update and process retroactive rate changes as they relate to providers or procedures and reprocess claims in history within two (2) checkwrites.
3.04.011	The Vendor shall update and process retroactive rate changes for Nursing Homes.
3.04.012	The Vendor shall update and process Medicaid policy changes as they relate to medical procedures and limitations when submitted by the Agency. The Vendor shall provide test results for approval prior to implementation as directed by the Agency.
3.04.013	The Vendor shall test changes to the drug file and receive approval from the Agency prior to implementation.
3.04.014	The Vendor shall notify the Agency of any newly approved drug products identified during the weekly drug file updates by the next business day.
3.04.015	The Vendor shall, without notification from the Agency, retrieve from the CMS website the annual ICD-9/10, Diagnosis and Surgical procedure codes. The information is available in August and will be applied by Sept 15th with an effective date of Oct 1st to the highest level of specificity.
3.04.016	The Vendor shall provide an Annual analysis to the highest specificity of the impacts that result from the ICD 9/10 Diagnosis and Surgical Procedure code updates. The analysis shall include but not be limited to: - new code to similar code/deleted code, - age, - gender, - BPA (Benefit Plan Administration), - recipient plan, - edits/audits, - diagnosis groups and - ICD Surgical procedure groups. The Vendor shall provide the analysis to the Agency by the first business day of September.
3.04.017	The Vendor shall apply updates from the annual ICD-9/10, Diagnosis and Surgical procedure codes once approved by the Agency to the appropriate reference files/database tables by Oct 1st.
3.04.018	The Vendor shall maintain on-line real-time a diagnosis data set of medical diagnosis codes utilizing ICD-9/10 coding system, which can maintain relationship edits for each diagnosis code, including: - Age - Sex - Place of service - Prior authorization - Inpatient length of stay criteria - Description of the diagnosis - Accident-related indicator

New #	Reference Requirements
3.04.019	The Vendor shall maintain multiple pricing methodologies by NDC number to be updated as part of the weekly drug file update process. The Vendor shall provide a report of changes to the Agency the next business day.
3.04.020	The Vendor shall maintain the capability to apply at the NDC level all pricing methodologies such as but not limited to FUL (Federal Upper Limit), AWP (Average Wholesale Price), WHN {Wholesale Acquisition Cost (WAC)}, DOJ (Department of Justice) and MAC (Maximum Allowable Cost).
3.04.021	The Vendor shall, without Agency notification, retrieve the annual HCPCS update file from CMS website. The information is available in November.
3.04.022	The Vendor shall provide an annual cross-reference of new/replacement codes to their original values to ensure an audit trail for quality assurance and other claim audits. The Vendor shall provide analysis of all impacts that occur as a result of the annual HCPCS code update such as but not limited to: - new code to similar code/deleted code - modifiers - age - claim type - quantity - unit type - place of service - pricing - gender - diagnosis - CLIA values - provider contracts - edits/audits - reimbursement rules - BPA rules - prior authorizations - procedure groups. The Vendor shall provide the analysis to the Agency the first Monday in December.
3.04.023	The Vendor shall apply HCPCS updates once approved by the Agency to the appropriate reference files/database tables by January 1st with an effective date of January 1st. The Vendor shall apply associated rate updates in accordance with the pricing chapter of the Claims Processing Manual. The Vendor shall suspend all claims impacted by the HCPCS update, if Agency approval is not received by Dec 31st. The Vendor shall include modifiers as part of the annual HCPCS update. The Vendor shall maintain a description of the procedure codes that match the HCPCS definition up to one hundred sixty (160) characters in length.
3.04.024	The Vendor shall update reference information on-line real-time with any change relating to Reference policy and pricing.
3.04.025	The Vendor shall perform batch updates of Reference file/database information from other update services (e.g., HCPCS, ICD-9/10, CPT, and NDC). The updates shall be done using maintenance hours.
3.04.026	The Vendor shall designate and provide a Code Set Coordinator to implement federally mandated updates such as HCPCS and ICD-9/10 and make recommendations to the Agency regarding fee schedules, policy, and pricing.

New #	Reference Requirements
3.04.027	The Vendor shall obtain Medicare Pricing Profiles on an annual basis and review them and other CMS Medicare policy statements to ensure conformance of Alabama reimbursement policy and MMIS pricing logic with Federal requirements regarding Medicare pricing or CMS changes. Certain procedures cannot be reimbursed at an amount greater than Medicare's allowed amount. The Vendor shall notify the Agency of any pricing noncompliance or CMS changes, according to Agency specifications for each POS and their impact on Alabama reimbursement policy and MMIS pricing logic immediately. The Vendor shall update Medicaid pricing file within thirty (30) calendar days from the Agency's approval date.
3.04.028	The Vendor shall retrieve and process the Medicare Fee Schedules and compare to Alabama Medicaid's fee schedule. The Vendor shall provide the comparison report to the Agency within three (3) days of request.
3.04.029	The Vendor shall retrieve the monthly Medicare Focus Bulletins and other Medicare Policy changes and review jointly in a face-to-face meeting with Agency staff on the last Wednesday of each month. Any changes identified and approved from the face-to-face meeting shall be completed within three (3) days of receipt of OPR.
3.04.030	The Vendor shall use Medicare Place of Service (POS) in all POS fields.
3.04.031	The Vendor shall provide consultation to Agency staff regarding medical policy and pricing and provide assistance with the understanding and development of both no later than one (1) day following request.
3.04.032	The Vendor shall identify and advise the Agency of proposed changes to edits and audits to enhance processing and efficiency and implement changes within three (3) days of Agency approval.
3.04.033	The Vendor shall maintain input and output codes to reflect editing of claims prior to and following TPL Matrix editing.
3.04.034	The Vendor shall update and utilize for claims processing the Medical Criteria and Parameter Files as approved or directed by the Agency upon receipt of an OPR (Operations Request) from the Agency within three (3) days unless otherwise directed by the Agency.
3.04.035	The Vendor shall establish prices for procedure codes in accordance with the Pricing Chapter of the Claims Processing Manual. The Vendor shall compare the established prices for procedure code to the Pricing Chapter of the Claims Processing Manual quarterly and report changes to the Agency within three (3) days of the review.
3.04.036	The Vendor shall recommend prices for those procedure codes which contain no price on file in accordance with the Pricing Chapter of the Claims Processing Manual. The Vendor shall use recommended pricing for claims processing pending approval by Agency. The Vendor shall supply the Agency a list of all recommended pricing updates with supporting data for approval weekly. In the event Medicaid approves a pricing amount different from that recommended by Vendor, the Vendor shall adjust those claims that have been paid using the recommended rate to the approved amount. Currently, approximately sixty-five (65) claims per month are manually priced by Vendor.
3.04.037	The Vendor shall review all Physician drug code list (non-pharmacy drugs) covered by the Medicaid Program semi-annually, with dates to be approved by Agency. The Vendor shall revise and update prices to be effective on dates defined by the Agency as specified in the Pricing Chapter of the Claims Processing Manual.
3.04.038	The Vendor shall publish the Physician drug code list (non-pharmacy drugs) in the provider billing manual on a quarterly basis. The Vendor shall provide updates through provider bulletins, on CD with the Provider Manual and on the Alabama Medicaid website.

New #	Reference Requirements
3.04.039	The Vendor shall publish the ASC (Ambulatory Surgical Center/Outpatient Hospital) list in the provider billing manual on a quarterly basis. The Vendor shall provide updates through provider bulletins, on CD with the Provider Manual and on the Alabama Medicaid website.
3.04.040	The Vendor shall compare Medicaid prices for clinical diagnostic laboratory services to the CMS national laboratory fee schedule "cap median" prices as they are retrieved from CMS website. The Vendor shall provide a comparison to Medicaid for review and/or approval no later than the end of January of each year. Under normal circumstances, the Vendor shall perform this comparison annually but the Agency may request the comparison on an as needed basis which the Vendor shall complete within three (3) days of receipt of request.
3.04.041	The Vendor shall produce and mail, semi-annually, with dates to be approved by the Agency, an Agency approved listing of practitioner license numbers to all pharmacy providers and other Medicaid providers on CD with the Provider Manual as requested. The Vendor shall include on the listing the license number and physician name for all records on file.
3.04.042	The Vendor shall provide the capability to update the Preferred Drug List (PDL) on-line real-time and produce a daily report of updates.
3.04.043	The Vendor shall provide the Agency with on-line real-time search and update capabilities to all Reference files with search by code and/or description depending upon the file or table being accessed.
3.04.044	The Vendor shall review all edits and audits currently in place (the current MMIS) and provide end to end test results to ensure edits and audits are working properly.
3.04.045	The Vendor shall deliver weekly, monthly, bimonthly, and quarterly reports indentified in the Alabama MMIS Reports Listing located in the Procurement Library.
3.04.046	The Vendor shall maintain Agency-approved updates for all reference files, including but not limited to: procedure; drug; diagnosis; provider-specific procedure pricing; recipient and/or program-specific pricing; edit/audit criteria, including medical policy and third party criteria; and edit disposition files.
3.04.047	The Vendor shall accept and maintain the minimum data prescribed by Part 11 of the State Medicaid Manual.
3.04.048	The Vendor shall maintain on-line real-time a diagnosis data set of medical diagnosis codes utilizing ICD-9/10 coding system, which can maintain relationship edits for each diagnosis code, including but not limited to: - Age - Sex - Place of service - Prior authorization - Inpatient length of stay criteria - Description of the diagnosis - Accident-related indicator.
3.04.049	The Vendor shall maintain flexibility in the diagnosis file to accommodate expanded diagnosis codes with the potential implementation of ICD-10.
3.04.050	The Vendor shall maintain a drug data set of the eleven (11) digit National Drug Code (NDC), which can accommodate weekly updates from a Agency approved updating service; the Drug data set must contain, at a minimum: -Therapeutic class indicator,

New #	Reference Requirements
	-Generic code or equivalent indicator, -Generic product indicator/brand product indicator, -Drug Coverage indicator, -Preferred Drug indicator, -Schedule Code, -DESI code, -Prior authorization indicator, -Pricing indicators to accommodate at minimum five (5) reimbursement methodologies, including FUL (Federal Upper Limit), AWP (Average Wholesale Price), WHN {Wholesale Acquisition Cost (WAC)}, DOJ (Department of Justice) and MAC (Maximum Allowable Cost), -Multiple prices, -Package size indicator, -Strength, -Unit type indicator, -Minimum and maximum indicator, -Indicator (and other information, as necessary) for drug rebate, -State-specified restrictions on conditions to be met for a claim to be paid (e.g., minimum/maximum days supply, quantities including fractional units, refill restrictions, recipient age, sex restrictions, medical review requirements, prior authorization requirements, etc.), -Description of the drug codes, -Information on drug usage and contradiction.
3.04.051	The Vendor shall maintain UB04 values including but not limited to revenue codes for use in referencing or billing claims that use UB04 claim forms. (E.g. hospital, Ambulatory Surgical Centers, dialysis clinics, home health agencies, nursing facilities, and others, as defined).
3.04.052	The Vendor shall maintain flexibility to accommodate multiple reimbursement methodologies, including but not limited to: - DRG - Per diem - Resource-based relative value scale - Level three with modifier percentage changes - Same procedure codes and use zero to four modifiers - Provider-specific pricing - Estimated acquisition cost - Maximum allowable charge - Federal upper limit.
3.04.053	The Vendor shall maintain, with on-line real-time update capability, an Edit/Audit Criteria table to provide a user-controlled method of implementing, for all claim types, service frequency, place of service, quantity limitations, and service conflicts for selected procedures and diagnoses, for calendar year, fiscal year, and once in a lifetime.

New #	Reference Requirements
3.04.054	The Vendor shall provide the on-line real-time capability to place edit/audit criteria limits based on but not limited to units of service or dollars, rate types by procedure code, revenue code, diagnosis code, and drug class, based on but not limited to: -Recipient age, sex, eligibility status, and program eligibility -Diagnosis -Provider type -Provider specialty -Place of service -Provider ID -Pro DUR drug alerts -Tooth number, surface codes and oral cavity designation -Floating or calendar year period -Fiscal year -Months, weeks or days periods -Once-in-a-lifetime procedures -Lifetime maximum allowable services
3.04.055	The Vendor shall maintain the capability on-line real-time to enforce valid place of service for procedure codes with or without modifiers.
3.04.056	The Vendor shall maintain the capability on-line real-time to define valid or invalid procedure combinations by either lists or ranges of combinations.
3.04.057	The Vendor shall maintain the capability on-line real-time to define valid or invalid diagnosis to procedure combinations by either list or a range of combinations.
3.04.058	The Vendor shall maintain current and historical reference data to be used in claims processing. The Vendor shall ensure all updates will be date specific with on-line real-time access to current and historical data for all reference information.
3.04.059	The Vendor shall maintain a Claim Edit Disposition data set with disposition information for each edit used in claims processing, including the disposition (pay, suspend, deny, pay and report) by submission medium (paper [with or without attachments], EMC) within claim type and by eligibility program(e.g. waivers, State-funded programs, etc.). For each error, the Vendor shall maintain the description of the error, the related remittance Explanation of Payments (EOP) codes, the HIPAA ARC/RRC/Entity/Claim status codes and descriptions and edit recycle times and frequency, with on-line update capability for all parameters and information. The Vendor shall obtain Agency approval for all new EOP messages developed by the Vendor.
3.04.060	The Vendor shall maintain a remittance and message text data set with access by edit number, the HIPAA ARC/RRC/Entity/Claim status codes and descriptions showing the MMIS message(s) for each error and the EOP message(s), with on-line update capability.
3.04.061	The Vendor shall provide capability to support provider-specific reimbursement, including at least sixty (60) date-specific pricing indicators, using these data elements: provider ID, payment location, specialty code, procedure code and modifier, encounter fees, type of service, and rates.
3.04.062	The Vendor shall maintain an on-line audit trail of all information changes, including date, user ID, source of change, and identification of changed data. The Vendor shall not use the system assigned key (SAK) fields as identification values of the audit trails.
3.04.063	The Vendor shall maintain an additional field on the procedure file that identifies what a unit represents (e.g. one (1) month, one (1) week, one (1) day, twelve (12) hours, etc.).

New #	Reference Requirements
3.04.064	The Vendor shall maintain the current system panels and on-line reports to support Recipient Lock-in.
3.04.065	The Vendor shall maintain on-line real-time other information for reference tables such as but not limited to accident-related values for possible TPL, values for required attachments, CLIA values and values for federal cost-sharing indicators, and prior authorization required.
3.04.066	The Vendor shall provide reports from Recipient Lock-in file, as defined in the Alabama MMIS Reports Listing located in the Procurement Library.
3.04.067	The Vendor shall provide on-line user manual to instruct Agency staff on accessing reference information. The Vendor shall maintain the on-line user manual to reflect current system functions. The Vendor shall provide hands-on user training for a minimum of twenty-four (24) Agency staff monthly or as requested by the Agency.
3.04.068	The Vendor shall support all Reference function, files, and data elements necessary to meet the requirements in this ITB and as specified by the Agency.
3.04.069	The Vendor shall interface weekly with a nationally known drug data warehouse approved by the Agency (e.g., First Data Bank, MediSpan). The data warehouse vendor shall maintain an active National Drug Database of detailed information on all drug products that have been assigned an eleven (11) digit National Drug Code (NDC) and shall meet all established criteria.
3.04.070	The Vendor shall provide weekly pre-processing drug reports to the Agency through COLD and hard-copy no later than the first day of each week unless otherwise specified by the Agency. Pre-processing reports include, but are not limited to: - added drugs - changed drugs - price updates - PDL updates - drugs added to Part D classification - any error reports.
3.04.071	The Vendor shall notify the Pharmacy Services staff when pre-processing reports are available.
3.04.072	The Vendor shall receive, coordinate, and apply weekly updates from an approved data warehouse on a regular time schedule that is approved by the Agency.
3.04.073	The Vendor shall maintain license agreement on behalf of the Agency with the data warehouse. The license agreement shall accommodate the average monthly claim count of 200,000 to 2 million. At the time of writing this ITB, the Agency averages 600,000 pharmacy claims per month (FY08).
3.04.074	The Vendor shall provide a user manual that describes each field, a defined meaning of each field, and specifications for the Reference subsystem.

New #	Reference Requirements
3.04.075	The Vendor shall provide weekly bulletins to Medicaid pharmacy department that consist of clinical and editorial updates, labeler updates, drug updates, and any additional information as provided by the data warehouse. • Clinical updates shall include any changes in the weekly file update that are related to clinical elements or clinical modules, including AHFS class changes and new drug data elements (i.e., TC, GSN or GCN, HIC3, or TC's). • Labeler updates shall include any updates on labeler status including the effective date and status of the labeler. • Editorial updates shall include any drug related topics that are not addressed in the weekly file update.
3.04.076	The Vendor shall provide a drug look up system for providers to sign into and look up prices and coverage (e.g., PA status, PDL status) information for specific NDC's. The Vendor shall obtain Pharmacy Service staff approval of the drug lookup system.
3.04.077	The Vendor shall provide Agency staff with the capability to update the Reference drug file online, real time. The update capability shall include, but are not limited to, pricing (e.g., AWP, FUL, SMAC, WHN, and DOJ), drug information changes, minimum and maximum unit changes, NDC group changes.
3.04.078	The Vendor shall provide three levels of therapeutic classification, approved by the Agency, in addition to the American Hospital Formulary Service (AHFS) classifications.
3.04.079	The Vendor shall provide unique codes to identify therapeutically equivalent products specific to strength and dosage form regardless of manufacturer. At the time of writing this ITB, the Agency uses GCN Sequence Number.
3.04.080	The Vendor shall maintain the capability to provide previous and replacement National Drug Code (NDC) numbers.
3.04.081	The Vendor shall maintain the capability to provide repackager, generic, brand, device, legend, over the counter, and other indicators as defined by the Agency.
3.04.082	The Vendor shall maintain the capability and provide DESI drug flags in accordance with the latest CMS regulations. DESI classifications of two (2), three (3), four (4), five (5), and six (6) shall be maintained on the drug file. The Vendor shall accommodate all DESI fields currently utilized by the Agency.
3.04.083	The Vendor shall maintain any drug information provided by the data warehouse that is currently not used in the Reference subsystem.
3.04.084	The Vendor shall provide a staff member as the primary contact for the Agency concerning the drug data warehouse. The Vendor shall provide a backup point of contact should the primary liaison be unavailable. The Vendor's point of contact for the drug data warehouse responsibilities shall include, but are not limited to: • Assist the Agency with any data warehouse related questions. • Contact the data warehouse to verify any information related to the drug file. • Return messages/correspondence from the Agency within one business day. • Meet with Agency staff upon request.
3.04.085	The Vendor shall ensure that the drug data warehouse identifies a primary and secondary point of contact. The Agency must have the ability to contact the data warehouse directly

New #	Reference Requirements
	without contacting the Vendor.
3.04.086	The Vendor shall maintain and implement rejection criteria for drugs and devices consisting of, but not limited to: • Any National Drug Code (NDC) that has been obsolete for more than one year • Any National Drug Code (NDC) that has been CMS terminated effective the date of termination • Any National Drug Code (NDC) that has been assigned a CMS DESI code of five (5) (Less than effective DESI/Identical Related and Similar (IRS) Drugs for all indications) • Any National Drug Code (NDC) that has been assigned a CMS DESI code of six (6) (Less than effective DESI/IRS Drugs removed from the market). • A repackaged manufacturer. • A non-participating federal rebate manufacturer that is specific at an NDC level. • Any optional drug class as outlined in the Omnibus Budget Reconciliation Act of 1990 (OBRA 90). The coverage of the below drug classes can change at any given time. The Vendor must code and implement any change on a timeframe that is approved by the state. The following drug classes are currently not covered by the state: a) DESI and IRS drugs which may be restricted in accordance with Section 1927(d)(2) of the Social Security Act b) Agents when used for anorexia, weight loss, or weight gain except for those specified by the Alabama Medicaid Agency c) Agents when used to promote fertility except for those specified by the Alabama Medicaid Agency d) Agents when used for cosmetic purposes or hair growth except for those specified by the Alabama Medicaid Agency e) Agents when used for the symptomatic relief of cough and cold except for those specified by the Alabama Medicaid Agency f) Agents when used to promote smoking cessation g) Prescription vitamin and mineral products, except prenatal vitamins and fluoride preparations and others as specified by the Alabama Medicaid Agency h) Nonprescription drugs except for those specified by the Alabama Medicaid Agency a. Covered outpatient drugs which the manufacturer seeks to require as a condition of sale that associated test or monitoring services be purchased exclusively from the manufacturer or its designee i) Barbiturates and benzodiazepines except for those specified by the Alabama Medicaid Agency j) Agents when used for the treatment of sexual or erectile dysfunction, unless authorized for medical necessity.
3.04.087	The Vendor shall provide the capability to show the preferred status of a drug.
3.04.088	The Vendor shall provide ability to update on-line real-time the preferred status of a drug. The preferred status indicators include: preferred, non-preferred, and not screened.
3.04.089	The Vendor shall maintain and provide the capability for the coding of the Preferred Drug List (PDL) to include but not be limited to the American Hospital Formulary Service (AHFS) level and at the National Drug Code (NDC) level.
3.04.090	The Vendor shall provide the ability to include the Preferred Drug List (PDL) edit in the claims process.

New #	Reference Requirements
3.04.091	The Vendor shall maintain tables of drugs that require prior authorization. The Vendor shall maintain any changes made to the prior authorization table. The Vendor shall make any changes that occurred evident on the panel when researching the drug.
3.04.092	The Vendor shall maintain an audit history of all changes made to the Reference drug prior authorization rule and make available on-line real-time. The Vendor shall make any changes that occurred evident on the panel when researching the drug.
3.04.093	The Vendor shall provide a prior authorization indicator on the Reference drug file and provide on-line real-time update capability on the drug information panel.
3.04.094	The Vendor shall provide the ability to include the prior authorization edit in the claims process.
3.04.095	The Vendor shall provide all Pharmacy reports defined in the Alabama MMIS Reports Listing located in the Procurement Library.
3.04.096	The Vendor shall produce and submit to the Medicaid Pharmacy Program, in formats approved by Medicaid, weekly or monthly pre-processing reports based on data provided by the data warehouse. The Vendor shall deliver weekly hard copy pre-processing drug reports to the Agency no later than the first day of each week or unless otherwise specified by Medicaid. The Vendor shall provide additional reports necessary to maintain the drug file upon Agency request.
3.04.097	The Vendor shall provide the following reports: 1. Drug update summary report. This report shall include drug information and drug records that were updated on the drug file during the data warehouse drug update. 2. Drug update error report. This report shall include every drug that was not updated due to some type of data warehouse error. The error should be notated on the report. This report should show the results of the drug file update during the data warehouse drug update. 3. Drug update report. This report shall include every drug that was updated during the drug file update. 4. Added drugs detail report. This report shall include every drug that is added to the drug file by the data warehouse. This report shall only include manufacturer rebate drugs, covered drugs, and new drugs on the drug file. Any drug that is added, is given an effective date of the following Friday. For example, if the update runs on Sunday night, the new drugs are given an effective date of that following Friday. 5. Changed drugs detail report. This report shall only include covered drugs that encountered a change on the drug file during the drug file update. Changes can include, but are not limited to, drug name, prior authorization, repackage indicator, generic/brand identification, minimum and maximum units, and part d classification. The report must show the before and after change for every field on the report. 6. Rejected drugs added. This report shall show every new drug that is added by the data warehouse that meets the rejection criteria outlined by the Agency. If at any time the coverage of a drug on the rejected report changes, the state should be notified to determine the coverage of a drug. 7. Error listing data base exceptions. This report includes any database errors that occurred during the drug file update. 8. Drug pricing update summary report. This report includes the price information that updated or changed during the drug file update. Every price type that was updated must be included in the report. The report must show the before and after price for each drug that was updated

New #	Reference Requirements
	with the file update. 9. Drug pricing add detail report. This report must include the prices for the drugs that are on the added drugs detail report. This report must show the price for each price type as provided by the data warehouse. 10. Drug pricing update error report. This report must show any errors that occurred during the drug file update with the data warehouse. 11. Drug pricing update detail report. This report must show any price changes that occurred with the data warehouse update. This report must show the before and after price for each drug that was updated with the drug file update. 12. State MAC price update report. This report should contain only covered drugs. If applicable, this report must show the drugs that have been calculated in the weekly state mac process. This report must include the before and after state mac price for each drug. 13. State MAC stack file report. This report should contain only covered drugs. If applicable, this report must show the drugs in a stack file that are used for calculating the SMAC price. This report does not need to be printed and sent with the weekly reports but the Agency must have electronic access to the report when needed. 14. Pharmacy standard classification review and update report. This report must show the drugs at National Drug Code (NDC) level that were inserted at a generic code grouping of similar drugs, drugs that were inserted in a generic code grouping with prior authorization restrictions, drugs that were inserted in a generic code grouping that have the same gender restrictions, or drugs that are in the same generic code grouping that have the same age restrictions. 15. Pharmacy Part D classification review/update report. This report must include all drugs that were added to the Part D classification when the drug file updated. 16. Pharmacy Preferred Drug List (PDL) screening report. This report must include all drugs that are screened in the PDL process. 17. Pharmacy Preferred Drug List (PDL) updates report. This report must include all drugs that are updated in the PDL process of the drug file update. 18. Preferred Drug List (PDL) assignment change report. 19. Drug Utilization Review reports. This is a series of reports that include a listing of all the drug utilization reviews that can occur. The Agency should have the option to activate or inactivate each drug utilization review edit criteria. The following reports are required by the Agency to be produced on a monthly basis: (NOTE: at any time a new drug utilization review criteria set needs to be added to the report list, the Vendor must add the report to the monthly report batch): • High Dosing Update Report. This report should show all the high dosage updates. • Adverse Drug Interaction Code Update Report. interactions updates. • Drug Age Update Report. This report should show all the drug age updates. • Over Utilization Update Report. This report should show all the over utilization updates. • Therapeutic Duplication Update Report. This report should show all the therapeutic duplication updates. • Contraindicated Disease Update Report. This report should show all the contraindicated disease updates. • Diagnosis to Disease Cross Reference Update. This report should show all the diagnosis to disease cross reference updates. • Pediatric Dosing Update Report. This report should show all the pediatric dosing updates. • Geriatric Dosing Update Report. This report should show all the geriatric dosing updates.

New #	Reference Requirements
	• Generic grouping code (formally GSN or GCN) Update Report. This report should show all the generic grouping code updates. • Specific Therapeutic Class Update. This report should show all the specific therapeutic class updates.
3.04.098	The Vendor shall maintain all drug-related reference fields in DSS.
3.04.099	The Vendor shall update the following DUR modules with data provided by the data warehouse. 1. Drug -Drug Interaction Module- this module should identify drug interactions and ways of preventing drug interactions. 2. Drug –Allergy Module- this module should identify potential allergic reactions and cross-sensitivities between drugs and known patient allergies and should also include allergy information on non-active ingredients. 3. Counseling Messages Module- this module should provide a set of prioritized counseling messages for both the patient and the professional. 4. Dosage Range Check Module- this module should monitor and identify the appropriateness of drug dosing. This module should use patient specific information to identify the safe dosage levels. All ages should be included in this module. 5. Drug-Disease Contraindication Module- this module should identify potential warnings for certain drugs when prescribed to patients with certain diseases, conditions, procedures or diagnostic test. 6. Drug-Food Interaction Module- this module should identify any potential interactions between certain drugs and certain foods. 7. Drug-Lab Interference Module-this module should identify potential undesired effects of drugs on lab-test measured values. This module should screen patient lab information and the patient's drug therapy along with referencing information on in-vitro drug lab conflicts. 8. Duplicate Therapy Module- this module should identify any interactions between new medication that is prescribed to the patient and any existing medication that the patient has. 9. Indications Module-this module should identify the appropriateness of a particular drug therapy given with a specific medical condition. This module should also include labeled and non-labeled indications. 10. Min/Max Dose Module- this module should identify the minimum and maximum dose range of a medication. This module should be a quick-check resource that includes information on the usual range of daily dose for adult, pediatric, and geriatric patients. 11. Patient Education Module (English)-this module should provide a patient monograph with each medication that is being prescribed. 12. Precautions Modules (Geriatric)-this module should identify any potential interactions or warnings with geriatric patients. 13. Precautions Modules (Pediatric)-this module should provide, at minimum, the sensitivities of drug therapies and any adverse effects for pediatric patients. Information should be based on specific age ranges. 14. Precautions Modules (Pregnancy)-this module should identify drug therapies that may not be appropriate for pregnant patients. Information in this module should include, but is not limited to, contraindications, potential risk, and any precautions. 15. Precautions Modules (Lactation)-this module should provide any warnings related to the

New #	Reference Requirements
	use of medications and nursing mothers. 16. Prescriber Order Entry Module (POEM) - this module should contain a database of medication orders and prescriptions with specific drug doses and frequencies that are clinically validated. This module should be designed to prevent prescribing errors.
3.04.100	The Vendor shall apply and maintain any changes, updates, or added information to drugs on a table level.
3.04.101	The Vendor shall apply and maintain any updates made by the Agency online, real-time.
3.04.102	The Vendor shall provide on-line real-time search capability to Reference drug file data to include all current and historical data.
3.04.103	The Vendor shall maintain on-line real-time update and search capability to the Reference drug file tables. The tables include, but are not limited to: • Minimum and maximum quantity-the minimum and maximum quantity must be updated on a GSN or GCN level. • Gender • Age • All the pricing types approved by the state • DESI • Covered drugs • Non-covered drugs • Obsolete dates • Prior authorizations • Termination dates • Drug Efficacy Study and Implementation (DESI) updates and changes. • DESI indicator clearly defined on NDC level. A DESI indicator is a one-character alphanumeric column that marks a particular drug as declared less than effective by the Food and Drug Administration (FDA) Drug Efficacy Study and Implementation program (DESI) • Maintain table for Drug Efficacy Study and Implementation (DESI) indicator changes. • Prior authorization updates not included in the Preferred Drug List. • Maintain minimum and maximum units table on generic grouping code (GSN or GCN) level and display information on the reference panel • Maintain age restrictions on NDC level and display information • Maintain refill limitations on NDC level and display information • Display effective date of NDC on drug file • Ability to classify drugs on an NDC level for Part D dual eligible recipients. • Ability to remove/add on an NDC level drugs to Part D classification • Maintain covered drugs in the MMIS system by the use of a drug coverage indicator. The drug coverage indicator must indicate the coverage of each drug at an NDC level, GCN SEQ number level, or drug name level. • Changes to the drug file must be real-time, online changes.
3.04.104	The Vendor shall provide semi-annually a report on the quarterly J Drug Pricing updates.

New #	Reference Requirements
3.04.105	The Vendor shall maintain the capability to link a National Drug Code (NDC) with the correct Healthcare Common Procedure Coding System (HCPCS) and CPT code. The crosswalk must contain all Medicaid covered NDC's. The covered NDC's must follow the rejection criteria as follows: • Any National Drug Code (NDC) that has been obsolete for more than one year • Any National Drug Code (NDC) that has been HCFA terminated • Any National Drug Code (NDC) that has been assigned a HCFA DESI code of five (5) (Less than effective DESI/IRS Drugs for all indications) • Any National Drug Code (NDC) that has been assigned a HCFA DESI code of six (6) (Less than effective DESI/IRS Drugs removed from the market). • A repackaged manufacturer • A non-participating rebate manufacturer that is specific at an NDC level • Any optional drug class as outlined in the Omnibus Budget Reconciliation Act of 1990 (OBRA 90). The following drug classes are currently not covered by the state. The coverage of the below drug classes can change at any given time. The contractor must code and implement any change on a timeframe that is approved by the Agency. - DESI and IRS drugs which may be restricted in accordance with Section 1927(d)(2) of the Social Security Act - Agents when used for anorexia, weight loss, or weight gain except for those specified by the Alabama Medicaid Agency - Agents when used to promote fertility except for those specified by the Alabama Medicaid Agency - Agents when used for cosmetic purposes or hair growth except for those specified by the Alabama Medicaid Agency - Agents when used for the symptomatic relief of cough and cold except for those specified by the Alabama Medicaid Agency - Agents when used to promote smoking cessation - Prescription vitamin and mineral products, except prenatal vitamins and fluoride preparations and others as specified by the Alabama Medicaid Agency - Nonprescription drugs except for those specified by the Alabama Medicaid Agency a Covered outpatient drugs which the manufacturer seeks to require as a condition of sale that associated test or monitoring services be purchased exclusively from the manufacturer or its designee - Barbiturates and benzodiazepines except for those specified by the Alabama Medicaid Agency - Agents when used for the treatment of sexual or erectile dysfunction, unless authorized for medical necessity.
3.04.106	The Vendor shall update the Reference drug file with the Federal rebate participation status based on NDC specific rebate information. The Vendor shall identify drugs on an NDC specific, not labeler code, level to ensure the most accurate information is utilized in determining covered drugs.
3.04.107	The Vendor shall notify the Agency within five (5) days of any DESI or newly recalled drugs identified during the periodic CMS Drug Rebate update.
3.04.108	The Vendor shall provide quarterly reports identifying NDCs that have changed coverage status due to CMS Drug Rebate update.
3.04.109	The Vendor shall non-cover any drug reported by CMS as terminated with the termination effective date assigned by CMS.

New #	Reference Requirements
3.04.110	The Vendor shall maintain the capability to update and report on multiple pricing types for each drug on the drug file as provided by the Agency approved data warehouse.
3.04.111	The Vendor shall update Reference drug file pricing data on a weekly basis.
3.04.112	The Vendor shall maintain all pricing methodologies as specified by the Agency.
3.04.113	The Vendor shall display on-line real-time the final price with percentages already calculated.
3.04.114	If at any time a pricing segment is added or inactivated, the Vendor shall not override the information unless authorized by the Agency.
3.04.115	The Vendor shall provide on-line real-time access to inactive pricing types.
3.04.116	The Vendor shall incorporate and maintain pricing methodologies as approved by the Agency and accommodate pricing methodology changes upon request. The current pricing algorithm used is the “lower of methodology” of all price types with a possible percentage differential. Please refer to the Administrative Code Rule No. 560-X-16-.06. Reimbursement for Covered Drugs for more information regarding reimbursement methodology. At the time of writing this ITB, the below pricing algorithms/reimbursement are utilized by the Agency: • Average Wholesale Price (AWP)-10% • Wholesale Acquisition Cost (WAC/WHN)+9.2% • State Maximum Allowable Cost (SMAC) • Federal Upper Limit (FUL) • Department of Justice (DOJ) • Usual & Customary (U&C)
3.04.117	Upon request by the Agency, the Vendor shall interface with Vendor(s) other than the data warehouse to obtain, maintain, and update the pricing file as defined by the Agency. In the event there is no State Maximum Allowable Cost (SMAC) vendor or third party, the Vendor shall be responsible for applying the State-approved logic for the State Maximum Allowable Cost (SMAC) price.
3.04.118	The Vendor shall maintain the drug reference file by applying the fields listed in the Drug Reference File Fields document located in the Procurement Library.
3.04.119	The Vendor shall make available to SureScripts-RxHub the following information which shall be available to Alabama e-prescribers with SureScripts-RxHub access: • Eligibility information • Medication histories • Benefit plan details, such as - Preferred Drug List - Prior Authorizations - Co-payments - Dosages - Drug Utilization Reviews - Quantity Limitations
3.04.120	The Vendor shall ensure transactions to Alabama’s MMIS are received from SureScripts-RxHub, so that recipient eligibility and medication history data can be exchanged.
3.04.121	The Vendor shall configure the AMMIS to respond to SureScripts-RxHub e-prescribing requests.

New #	Reference Requirements
3.04.122	The Vendor shall provide SureScripts-RxHub with the Agency's drug PDL and benefit information by providing data files that break down the Agency's drug benefit and policy rules into the following categories: • PDL Status • Drug Classification • Coverage Text Message • Product Coverage Exclusion • Prior Authorization • Quantity Limits • Age Limits • Gender Limits • Resource Link • Benefit Co-pay • Cross-Reference Detail Updates to any of these categories shall be sent to SureScripts-RxHub within twenty-four (24) hours of notification by the Agency.
3.04.123	The Vendor shall provide SureScripts-RxHub with the preferred status of the Agency drugs. The Agency currently supports one PDL listing for all benefit groups.
3.04.124	The Vendor shall create a new AMMIS on-line panel to support drug classifications. This panel shall allow a user to enter a drug, GFC (Generic Formula Code), or list where an alternatives class ID or subclass ID can be listed. These rules shall be based on a recipient's eligibility program to allow flexibility that drug classifications can be different among programs. The Vendor shall extract all active drug classification rules and send them to SureScripts-RxHub along with the drug classification ID, which associates the drug data with a recipient's program.
3.04.125	The Vendor shall create a new AMMIS on-line panel to support specific NDC related text messages. This panel shall allow a user to enter a National Drug Code (NDC), Generic Formula Code (GFC), or list along with a two hundred (200) character text message. The Vendor shall extract all active text message rules and send them to SureScripts-RxHub. This transaction shall allow specific messages to be conveyed about particular drugs.
3.04.126	The Vendor shall transmit a product coverage exclusion transaction which allows exclusion criteria related to an NDC to be returned to SureScripts-RxHub. Products for nonparticipating manufacturers shall be returned in this transaction, specific to the eligibility program that is applicable.
3.04.127	The Vendor shall return current, active, payable NDCs requiring prior authorization (PA). This shall provide SureScripts-RxHub with all the current drugs where a PA is required, based on the PA indicator on the Agency's drug file.
3.04.128	The Vendor shall allow NDCs to be returned in the extract file when the NDC has a quantity limit. All records sent to SureScripts-RxHub shall be NDC-specific, and the data provided shall include the drug, maximum quantity, and time period associated with the quantity.
3.04.129	The Vendor shall return each current, active, payable NDC with an age restriction. This shall provide SureScripts-RxHub with all the current drugs where age restrictions are applicable, based on the age criteria on the Agency's drug file. This transaction can specifically address recipient fraud if the same names are used between generations and only the children qualify for the program.
3.04.130	The Vendor shall return each current, active, payable NDC with a gender restriction. This shall

New #	Reference Requirements
	provide SureScripts-RxHub with all the current drugs where gender restrictions are applicable, based on the gender criteria on the Agency's drug file.
3.04.131	The Vendor shall provide the capability for a Web link to be returned to SureScripts-RxHub in the extract file. Web links are useful for providing a pathway to prescribers for forms or information that may be needed during the prescription-generating processes. For example, links to prior authorization forms are provided when the forms are required to prescribe certain prescriptions. There are two types of resource link transactions. There is a resource link summary transaction and a resource link drug-specific transaction. For each transaction, a resource link "type" shall indicate the type of information being conveyed. There are ten types of resource links allowed: Age Limit, Product Coverage Exclusion, Gender Limits, Medical Necessity, Prior Authorization, Quantity Limits, Step Therapy, General Information, Co-pay, and Formulary. The resource link drug-specific transaction is associated with a drug where the summary transaction is not. Updates to resource links shall be part of system maintenance.
3.04.132	The Vendor shall allow specific Agency co-pay rules to be returned. These rules shall be based on a recipient's eligibility program to allow reporting flexibility for the different programs. Although Agency policy currently supports one co-payment based on the cost of the medication, this functionality shall provide a means of communicating to the practitioner whether a tiered co-payment would be applied if Agency policy changes, based on the flexibility allowed with the passage of the Deficit Reduction Act.
3.04.133	The Vendor shall create a new AMMIS on-line cross-reference detail panel to support the recipient's formulary and benefit information. This panel shall allow a user to enter a health plan name associated with an aid category list, alternative ID, coverage ID, co-pay list ID, and classification ID. All this information shall be used to support the interactive eligibility request that is sent through SureScripts-RxHub. This panel ties a recipient's benefit information together and allows a prescriber to access the recipient's benefit information.
3.04.134	The Vendor shall provide SureScripts-RxHub the Agency's recipient information from the AMMIS. The Vendor shall send a one-time master file, followed by nightly updates based on changes to recipient data. The information shall be sent in the SureScripts-RxHub file layout along with all the data elements being requested. SureScripts-RxHub shall use these files to establish uniqueness for recipients among the different third-party vendors.
3.04.135	The Vendor shall provide a recipient's prescription medication history to SureScripts-RxHub from the AMMIS via the current NCPDP Script medication history transaction format. This transaction allows the flexibility for up to fifty (50) paid history prescriptions to be returned to a valid Agency provider/prescriber. The number of claims returned in the response shall be based on the number of prescriptions the recipient has in history, the age of the claims, and ensuring adequate response times. Paid prescription data within a specified time period shall be gathered from the AMMIS and returned in this transaction, based on SureScripts-RxHub's data requirements. The Vendor shall optimize response times so that response time does not limit the maximum number of scripts that are returned.
3.04.136	The Vendor shall modify the 270 and 271 eligibility request and response transactions to provide additional information to SureScripts-RxHub specific to a recipient's benefit and PDL information. Additional processing rules, within the HIPAA guidelines, are requested to support SureScripts-RxHub's processing. These processing rules shall be incorporated into this transaction to aid SureScripts-RxHub. The PDL and benefit load information shall be retrieved from the new AMMIS on-line panel under this cross-reference detail transaction. By using the benefit IDs returned in this transaction, a prescriber can access a recipient's PDL information through SureScripts-RxHub.

New #	Reference Requirements
3.04.137	The Vendor shall report transactions for requested recipient eligibility and medication history data on a monthly basis. The Vendor shall include reporting data for point-of-care (POC) technology vendor participation, transaction performance, and trending analysis for e-prescribing adoption and use. There are two main data sources for the transactions statistics—one from SureScripts-RxHub and the other from the AMMIS system. The information from both sources shall be combined to present reports that summarize all the available data. Reports shall be provided to the Agency the 5th day of the month.
3.04.138	The Vendor shall report prescription-related counts and related information as data becomes available
3.04.139	The Vendor shall make available through the existing WEB Portal the ability to perform full electronic prescribing capabilities. Interactive, real-time patient data should enable full clinical decision support and electronic transmission to any pharmacy in the SureScripts network. The ePrescribing module shall be fully certified with the SureScripts Health Information Network and enrolled Medicaid providers should have the ability to service all of their current and future patients. The provider portal should offer a no-cost option, assuming the provider has access to the Internet at their office.
3.04.140	The Vendor shall update and maintain the HCPCS to NDC Crosswalk on a weekly basis after the Data Warehouse (Currently FDB) has been applied.
3.04.141	The Vendor shall provide adequate staffing to maintain the HCPCS to NDC crosswalk.
3.04.142	The Vendor shall provide a panel which will display the lowest reimbursable rate utilizing the current lower of pricing methodology provided by the Agency.
3.04.143	The Vendor shall implement Correct Coding Initiatives (CCI) Edits for physician and outpatient hospital claims in accordance with CMS guidelines. The Vendor shall meet with the Agency prior to the initial implementation of the CCI Edits to identify those applicable to the Alabama Medicaid Agency.
3.04.144	The Vendor shall subscribe to CMS quarterly updates for the CCI Edits. CMS sends notifications quarterly of the changes to the CCI Edits. The Vendor shall meet with the Agency within five (5) days of the CMS email notification to determine the CCI Edits applicable to the Agency. The Vendor shall implement the Agency approved CCI Edits within ten (10) days of obtaining Agency approval.
3.04.145	The Vendor shall review all CCI edits identified and provide end to end test results to ensure edits are working properly prior to implementation. This shall include regression testing.
3.04.146	The Vendor shall furnish comparison reports of the non-pharmacy drugs to the Agency no later than fifteen (15) days prior to the effective date of the updates (currently this report is REF-04502-Q -- Quarterly J code Pricing Update Detail). The comparison report shall contain the following elements: - Procedure code; - Procedure code description; - Medicaid Price; - Medicare's New Price; - Medicaid greater/Medicare greater comment; - Difference in price. The report shall contain all non-pharmacy drugs regardless of a pricing change. If the price did not change, the system will not be updated.
3.04.147	The Vendor shall identify all non-pharmacy drug procedure codes that are not priced by

New #	Reference Requirements
	Medicare and must manually review these procedures codes and make recommended updates in accordance with the Pricing Chapter of the Claims Processing Manual.

3.05 Prior Authorization (PA) Requirements

Prior Authorization (PA) is a mechanism to review, assess, and pre-approve or deny selected non-emergency medical services prior to payment. PA serves as a cost-containment and utilization review mechanism, enabling payment for only those treatments and services that are medically necessary, appropriate, and cost-effective.

The AMMIS PA functional area supports the following functions and processes:

- Direct Data Entry (DDE) and HIPAA 278 Electronic Data Interchange (EDI) submissions of requests for medical and dental services.
- Direct Data Entry (DDE) and POS transactions using NCPDP P4 HIPAA transaction requests for pharmacy services.
- Generation of PA Notices to communicate decision information to both recipients and providers.
- Integration with claims processing to provide online, real time processing and adjudication of claims against PA requests.
- Integration with other functional areas to provide online, real-time access to Provider, Recipient and Reference data, including front-end editing and validation of keyed requests into the online application Web-based panels.

The following are the requirements identified by the Agency that must be met by the Vendor to support the successful operation of the Prior Authorization related functions.

New #	Prior Authorization Requirements
3.05.001	The Vendor shall support automated distribution of PA requests to appropriate Medicaid staff and its agents.
3.05.002	The Vendor shall process and assign a unique reference number to all PAs received from Providers, Agency staff or Agency contractors within two (2) days of receipt. Pharmacy electronic PA requests must be accepted online, real-time.
3.05.003	The Vendor shall respond to telephone inquiries, written inquiries and questions from providers and recipients regarding prior-authorized services within two (2) days of inquiry.
3.05.004	The Vendor shall auto-assign unique prior authorization control numbers to prior authorization items/services at time of entry into the system.
3.05.005	The Vendor shall create and distribute PA forms, in electronic and paper formats, to providers at no charge.

New #	Prior Authorization Requirements
3.05.006	The Vendor shall maintain and update PA files/database tables to support all prior-authorized services.
3.05.007	The Vendor shall research PA or certification issues or problems identified by the system and/or operational staff; obtain documentation, determine impact, present findings to system support area; and perform further reviews once the issue/problem is fixed. The Vendor shall provide analysis and estimated date of correction within three (3) days of notification of any issues or defects.
3.05.008	The Vendor shall edit prior authorization requests entered into the MMIS, including verification of the eligibility of the recipient and provider for the PA request being made, including Medicare and other TPL coverage and HMO enrollment, as well as all field verifications and inter-field relationships (i.e., approved status but presence of a denial reason code).
3.05.009	The Vendor shall designate a Targeted Case Management (TCM) Prior Authorization Coordinator who shall be responsible for issuing prior authorization numbers to providers for Targeted Case Management for Disabled Children. Based on a telephonic request (a separate phone line is not required) from the provider, the coordinator shall review the Prior Authorization File to determine if the child is already receiving services. If not, the coordinator shall assign a prior authorization number and load it to the file within two (2) days of the request. The Vendor shall produce a follow-up letter and a report the next day following each update. If the child already has a prior authorization number, the Vendor shall instruct the provider to contact Medicaid's LTC- Program Management Unit.
3.05.010	The Vendor shall automatically generate and mail letters to notify recipients of approvals and duration, denials or modifications of the PA request per Agency defined criteria and provide information regarding recipient appeal rights within time frame specified by Agency.
3.05.011	The Vendor shall display on-line real-time the status of PAs, including returned, pended, approved, denied, cancelled, or amended, active or inactive.
3.05.012	The Vendor shall maintain and update PA records based on claims processing to indicate that the authorized service has been used or partially used, including units and/or dollars (decrement when appropriate); increment units and/or dollars when necessary.
3.05.013	The Vendor shall deny claims for any service that has been performed by a provider or group other than the provider or group authorized for the PA services.
3.05.014	The Vendor shall make available on-line real-time, the number of authorized services provided and show how many authorized services remain, by individual prior authorization numbers.
3.05.015	The Vendor shall produce and make available to the Agency and/or their contractors all PA reports defined in the Alabama MMIS Reports Listing located in the Procurement Library.
3.05.016	The Vendor shall develop recommendations regarding policy guidelines which are unclear and/or cause problems in adjudicating PA requests. The issues may be identified by the Vendor, the Agency or their PA Contractors. These recommendations are to be forwarded to the State in writing (on paper or electronically) within two (2) days of identification and/or notification.
3.05.017	The Vendor shall provide EPSDT screening data for recipients who are eligible for extended

New #	Prior Authorization Requirements
	benefits through prior authorization on-line real-time.
3.05.018	The Vendor shall review and enter all paper PA forms from providers within two (2) days of receipt. The Vendor shall review all paper forms for completeness prior to entry into the MMIS and return incomplete forms to providers within two (2) days of receipt.
3.05.019	The Vendor shall support online submittal and response of the electronic PA (HIPAA ASC X12N 278 4010 & 5010) transaction. The Vendor shall also allow the providers to modify a request prior to its review or approval. The Vendor shall allow the providers access to electronic and paper PA requests (e.g., oxygen, home health, etc).
3.05.020	The Vendor shall provide capability for auto-approval of basic Pharmacy PA requests based on Agency specified criteria and systematic generation of PA status letters within one (1) day of auto-approval.
3.05.021	The Vendor shall accept on-line, real-time updates to PA information from the Agency or their contractors. For pharmacy claims, prior authorization updates must be accepted from the Pharmacy Administrative Services contractor online real-time for immediate use in electronic transactions or Electronic Verification System (EVS) processing.
3.05.022	The Vendor shall provide the capability to globally change data, for example, provider ID numbers or procedure codes or modifiers, on active or pending PAs within an Agency approved timeframe.
3.05.023	The Vendor shall respond to provider's requests for the status of PAs within one (1) day, or within the timeframe specified by the state for pharmacy PAs.
3.05.024	The Vendor shall maintain an on-line real-time PA data set to include but not be limited to the following information: - Unique PA number - Beginning and ending effective dates of the PA - Assignment/Service Code - Tooth Number - Cross reference to claims paid and date paid under the PA - Identification of PAs that have been appealed and the outcome of the appeal - ID of authorizing person - Change reason code - Date of PA request and date of request for additional information - ID of the requesting provider - Denial reason code - Date of PA decision - Date PA notice sent - Comments area, both internal and external - ID of the rendering/performing provider - Recipient ID for whom services are being requested. - Other client identification information, such as name and date of birth - Status of the PA request, including pending, denied, approved, modified or closed, active or inactive - Recipient-specific pricing indicators and unit price.
3.05.025	The Vendor shall provide on-line real-time inquiry access and update capability for Agency and Contractor staff to the PA request data set (e.g. pending requests, approvals, denials,

New #	Prior Authorization Requirements
	and PAs for which all services have been used or the PA closed), with access by recipient ID, rendering provider ID, requesting provider ID, PA number, and procedure or drug code.
3.05.026	The Vendor shall maintain HIPAA defined security for accessing PA data by requiring provider's ID or user ID and assigned passwords.
3.05.027	The Vendor shall accept on-line, real-time entry and modification of PA requests from the Agency authorized staff or contracted entities (e.g. HID).
3.05.028	The Vendor shall provide the on-line real-time capability for authorized users to modify the number of units and/or the dollar amounts of approved PAs; both the amounts billed and authorized.
3.05.029	The Vendor shall maintain an audit trail for batch or on-line changes and display on-line real-time the date of last change, ID of person initiating change, and information changed for each PA record.
3.05.030	The Vendor shall edit to prevent duplicate PA numbers and duplicate services across programs (e.g. same service, same span, same recipient, any provider) from being entered into the system as defined by the Agency. The vendor shall provide override capability to selected Agency or contractor staff.
3.05.031	The Vendor shall edit and validate PAs at time of entry to include but not be limited to: - Procedure codes - Diagnosis codes - NDC codes - Revenue codes - Valid tooth number and tooth surface - Presence of required claim-type-specific data on the PA.
3.05.032	At the time of entry on electronic PAs, the Vendor shall reject the PA request containing errors. The Vendor shall return information identifying the specific field in error and the particular edit that failed.
3.05.033	The Vendor shall accept on-line, real-time corrections to PAs in evaluation status (PAs that have not been approved, denied, pended or suspended).
3.05.034	The Vendor shall maintain a minimum of five (5) years of PA records. The current system does not purge data. Any purge process must have Agency approval.
3.05.035	The Vendor shall generate approval and denial notices to the Agency within two (2) days of decision or within the timeframe specified by the Agency for pharmacy PAs. The notice shall be generated using variable parameters (e.g. specific name or address, or to send notices to more than one (1) provider). The notices shall include but not be limited to, procedure codes and modifiers (including descriptions), denial reason, and appeal rights and procedures, Electronic requests shall receive real-time electronic responses.
3.05.036	The Vendor shall identify PA requests for which an administrative review request has been submitted, indicate the outcome of such reviews, and identify PAs for which an appeal has

New #	Prior Authorization Requirements
	been filed.
3.05.037	The Vendor shall provide the on-line real-time capability to display only those data elements pertinent to a specific assignment/service code (e.g. pharmacy, medical, dental).
3.05.038	The Vendor shall provide the capability for providers to initially submit or modify electronically a request prior to its approval and, once approved, to be limited to online inquiry only. Provider inquiry must be limited to only those records for which the provider is the rendering provider and adequate security measures must be installed.
3.05.039	The Vendor shall provide monthly Utilization reports (including the number of times particular services were approved), by both the requesting and the rendering/performing providers, assignment/service code, PA number, and recipient.
3.05.040	The Vendor shall provide an on-line real-time report of denials (including denial reason), approvals, and pending (including pending reason).
3.05.041	The Vendor shall provide an on-line real-time report of Pending PA's, sorted by assignment/service code, including the date of entry for each PA.
3.05.042	The Vendor shall provide reports of the timeliness of PA processing, including days from receipt of request to mailing notices; numbers of PAs approved, denied, and pending; and an aging report of PAs in the system by type.
3.05.043	The Vendor shall provide a report of PAs that are subject to review or appeal proceedings.
3.05.044	The Vendor shall provide the capability for providers to download HIPAA compliant 278 PA response files.
3.05.045	The Vendor shall provide a monthly report on PA decision, assignment/service code (NDC, procedure code/modifiers, and tooth number), PA number, number of services approved/denied by authorizer, units (used and not used), and dollar value (used and not used).
3.05.046	The Vendor shall provide an on-line real-time report of pending PA's and suspect duplicates.
3.05.047	The Vendor shall provide a monthly report on frequency of assignment/service codes requested and authorized.
3.05.048	The Vendor shall provide capability for providers to inquire on the status of a PA through Automated Voice Response System (AVRS).
3.05.049	The Vendor shall interface with the Electronic Claims Management System to update PAs.
3.05.050	The Vendor shall provide data extracts for sub-contractors and Pharmacy PA contractor to include but not be limited to recipient, provider, reference, claims and financial. These are to be provided on a schedule approved by the Agency.
3.05.051	The Vendor shall accept and process nightly updates to the PA data set from Agency specified contractors.
3.05.052	The Vendor shall designate a Prior Authorization Coordinator who shall be responsible for issuing PA numbers to providers for Dental prior authorizations.

New #	Prior Authorization Requirements
3.05.053	The Vendor shall receive Dental PAs and assign a PA number and forward to the Agency's dental consultant within two (2) days of receipt.
3.05.054	The Vendor shall update PA decision into the system when received from the Agency's dental consultant and produce follow-up letters within forty-eight (48) hours of receipt.
3.05.055	The Vendor shall produce and transmit a nightly error report file for the Agency contractors before 7:00 A.M.
3.05.056	The Vendor shall receive PA attachments in paper format and link the PA to the attachment and the attachment to the PA at the time of entry.
3.05.057	The Vendor shall maintain and make available through COLD PA s with attachments (e.g. paper, electronic, and reconsiderations), that are denial, approve, and conditional notices.

3.06 Claims Requirements

Claims and Encounter processing functions ensure claims for eligible recipients, received from enrolled providers for covered services, are accurately processed and adjudicated in accordance with State and Federal requirements. The Claims processing function encompasses the tracking and processing of claim transactions up through adjudication. Data from Reference, Provider, Recipient, Prior Authorization, Third-Party Liability (TPL), and Claims History is used in processing claims. The Encounter processing function encompasses the receipt, data validation, and processing of encounters. The data used in claims processing is also used for encounter validation.

The AMMIS provides a user-driven and maintainable claims processing environment. Data elements owned by the AMMIS are captured and stored with a single key name in one physical location within the database, and are accessed by all the other AMMIS processes. A majority of claims processing, such as edit and auditing, claims pricing, claims disposition, and claims adjudication, are completed in their logical entirety for each claim processed.

The AMMIS Claims Processing function includes:

- Claims entry which ensures the accuracy, reasonableness and integrity of AMMIS entered data for further processing.
- Claims receipt and control which ensures all claim records are captured at the earliest possible time and in an accurate manner.
- Edit/Audit processing which ensures that claim records are processed in accordance with state policy.
- Claims pricing which calculates the payment amount for each service according to the rules and limitations applicable to each claim type, category of service, and type of provider.

- Claims resolution which supports the correction of suspended claims.
- Point Of Sale (POS)/Prospective Drug Utilization Review (PRODUR) which provides for the on- line processing of pharmacy claims submitted in real-time by pharmacist and prevents the dispensing of inappropriate drugs through direct intervention.
- Adjustment processing which supports the adjustment of previously adjudicated claims.
- Claims Dispositioning which lists tips on how to set up dispositioning for edits and audits.

The following are the requirements identified by the Agency that must be met by the Vendor to support the successful operation of the Claims related functions. This includes the Electronic Verification and Claims Management (EVCM), Claims, Control and Entry (CCE), Claims Encounter Pricing and Adjudication functions.

New #	Claims Requirements
3.06.001	Electronic Verification System and Claim Management: The Vendor shall maintain an Electronic Verification System (EVS) that shall consist of two (2) components: an automated voice response system (AVRS) accessible through touch-tone phone and an electronic claims management (ECM) system accessible through PC/modem connection or point-of-sale (POS) devices.
3.06.002	The Vendor shall maintain a Help Desk to assist providers and network vendors with EVS and ECM access and other technical problems. The Vendor shall employ one (1) full-time EMC coordinator and adequate staff to answer a minimum of three (3) lines to provide training; and assist providers in the submission of claims and in the resolution of claims processing problems. A toll-free telephone line, with voice mail capability, shall be provided for accessing the Help Desk that shall be available as stated below, including holidays. (Note, on Thanksgiving and Christmas, service may be provided via on-call pager service from 9:00 a.m. to 5:00 p.m. and on Christmas Eve, on-site staff may leave at 5:00 p.m. and provide service through an on-call pager service from 5:00 p.m. to 10:00 p.m.) The Vendor's on-site staff shall be available from 7:00 a.m. to 8:00 p.m. and on-call through a pager service from 8:00 p.m. to 12:00 a.m. Monday through Friday. On-site staff shall be available from 9:00 a.m. to 5:00 p.m. Saturday and on-call through a pager service from 5:00 p.m. to 10:30 p.m. Saturday and 12:00 p.m. to 5:00 p.m. Sunday.

New #	Claims Requirements
3.06.003	The Vendor shall provide to providers for all recipients through the Automated Voice Response System (AVRS): - information on eligibility, - household inquiry by Payee, - managed care, - Prior Authorization information, - TPL information to include multiple insurance coverage if applicable; - Medicare coverage, - benefit limitations, and - claims status. The Vendor shall provide through AVRS: - procedure code pricing, - NDC Pricing, - certain limitations, and - provider checkwrite information. The Vendor shall provide fax service on the above information when requested by the provider.
3.06.004	The Vendor shall provide an Agency approved electronic verification and claims management system equivalent to the existing Provider Electronic Solutions Software (PES). The Vendor shall provide free of charge PC-based Windows compatible software, including future updates, and installation support to providers for PC interface with the OLTP (toll-free line). The Vendor shall make available the software updates on the Medicaid WEB Site for downloading by providers.
3.06.005	The Vendor shall provide the capability to notify providers through voice response that the AVRS system is not available. The notification for AVRS must be accomplished in a way that does not require the user to enter a transaction before being notified of the down status. The Vendor shall provide dial-up messaging that notifies the caller that the system is temporarily down and provides instructions on caller action options.
3.06.006	The Vendor shall ensure that data used for AVRS, ECM and the Web Portal is the same.
3.06.007	The Vendor shall maintain an AVRS weekly log of: - all telephone and electronic inquiries, - pricing inquiries, - coverage limitations as identified by the Agency, and - provider checkwrite information.
3.06.008	The Vendor shall provide an automatic connection to a provider representative at the end of AVRS script for telephone inquiries during normal business hours, with messaging capability for other hours of the day
3.06.009	The Vendor shall verify that the caller is an authorized provider or other authorized user, and allow access to data by Medicaid recipient ID or SSN with date of birth.
3.06.010	The Vendor shall provide availability to the telephone AVRS system and ECM eligibility inquiries twenty-one (21) hours per day (downtime limited for routine maintenance to the hours of 2:00 a.m. to 5:00 a.m. daily) seven (7) days per week utilizing at a minimum thirty-

New #	Claims Requirements
	two (32) toll-free telephone lines. (Both systems must not be down at the same time.)
3.06.011	The Vendor shall complete daily source file updates by 5:00 AM.
3.06.012	The Vendor shall produce and distribute user manuals, reference cards, and other related documentation to providers and Agency staff.
3.06.013	The Vendor shall provide for telephone inquiries from recipients via the recipient call center.
3.06.014	The Vendor shall provide the capability for batch transmissions of the following, using a translator as necessary for HIPAA mandated electronic standards: - Eligibility (270/271) - Claim Status (276/277) - Prior Authorization (278) - Electronic Remittance Advice (835) - All non-drug Claims (837) - Functional Acknowledgment (997) - NCPDP - Pharmacy Claims - BRF - Batch Response File.
3.06.015	The Vendor shall notify providers within twenty-four (24) hours of the status of their transmissions. If rejected, notify provider of nature of errors, and if no errors, accept the transactions for further processing. If errors are present that prevent the entire electronic submission from being entered into the system, the submission shall be returned to the provider for correction and resubmittal.
3.06.016	The Vendor shall maintain records of all EVS inquiries made, information requested, information conveyed and rejected transaction results, as applicable.
3.06.017	The Vendor shall provide the capability for recipients to perform the following inquiries via the Recipient VRS system: Claims Status and Eligibility
3.06.018	The Vendor shall provide on a monthly basis EVCM Helpdesk operational reports about the number of inquiries received during the month, by hour segment and day. The monthly report will cover the previous month's activity and be provided no later than 5th day of the following month. The report shall include but not be limited to statistics on the following: - calls answered; - busy signals; - electronic connections made; - average waiting time; - number of abandoned calls; - incomplete calls; - average time per call; - counts and types of inquiries by provider type, and individual providers. The Vendor shall track and identify caller Id statistics and provide to the Agency upon request.
3.06.019	The Vendor shall interface with: - MMIS - Agency Staff

New #	Claims Requirements
	- Switching networks and VANs - Providers and - other External entities as specified by the Agency
3.06.020	The Vendor shall establish and document Agency approved controls to ensure no mail, claims, claim attachments, tapes, or diskettes are misplaced after receipt by the Vendor.
3.06.021	The Vendor shall provide electronic claims specifications to providers and health plans to permit electronic submission of claims to the Vendor.
3.06.022	The Vendor shall maintain incoming asynchronous lines that provide access to claims submission and eligibility verification for those providers who do not have Internet access. The Vendor shall maintain at a minimum of thirteen (13) incoming asynchronous lines. The availability of these lines shall be seven (7) days per week, twenty-four (24) hours per day with down time for transmissions to the host processor and for approved maintenance. Claims requiring attachments may not be submitted via electronic media except as specifically allowed.
3.06.023	The Vendor shall obtain written agreements from billing agencies and providers using electronic claims submission methods certifying their compliance with Medicaid requirements prior to payment of any EMC claims. Existing EMC agreements shall remain in effect and paperwork shall be transferred to new Vendor during transition. Agreements should include but not be limited to: - administrative access for creating, deleting, setting permissions and resetting passwords for all trading partners; and - user access for updating their profile. The Vendor shall make agreements available on COLD.
3.06.024	The Vendor shall review daily EMC transmittal documents accompanying tape and diskette submissions and verify that all records submitted are loaded. The Vendor shall notify the Agency within one (1) day of any discrepancies and provide control totals monthly by the 5th day of each month.
3.06.025	The Vendor shall capture all reference indicators as they are submitted on the claim by the provider. The Vendor shall accept these indicators and place them on the stored images of claims.
3.06.026	The Vendor shall accept and process all claim types on paper. The forms shall include but not be limited to: - CMS-1500 claim form - UB-04 claim form - Pharmacy claim form (Agency unique) - American Dental Association Standard claim form - Encounter claims that are processed through the MMIS as fee for service claims up to, but not including, payment - Medical Crossover Form (Agency unique)
3.06.027	The Vendor shall provide the Agency access to mailroom claim samples as specified by the Agency prior to data imaging for contract monitoring and Agency review.

New #	Claims Requirements
3.06.028	The Vendor shall arrange with applicable Medicare carriers/intermediaries for receipt of Medicare crossover claims through electronic media.
3.06.029	The Vendor shall receive and reformat key-entered and EMC claims, including Medicare crossover claims, into common processing formats for each claim type. The Vendor shall receive crossover claims transmissions from Medicare and process within one (1) day of receipt.
3.06.030	The Vendor shall provide the Agency, upon request, imaged or hard copies of original claims, adjustments, attachments, and non-claim transaction documents within ten (10) days of request.
3.06.031	The Vendor shall perform a weekly quality control random sample of images from each of the following: - Two (2) claim facsimiles for each claim type from each region; and - Two (2) facsimiles for other captured images. The Vendor shall generate the Random Sample ICN Report (CLM-0640-W) each Friday night and the report shall be placed on COLD by Monday 7AM. The Vendor shall provide a copy of the actual claims reviewed to the Agency each Tuesday by noon.
3.06.032	The Vendor shall establish balancing procedures to ensure control within the MMIS processing cycles to include balancing claims history against claims financial. The claims extract process shall generate control totals to be compared / matched to the approved to pay report prior to transmission of claims files to Agency and other vendors. The totals shall be provided by header status and fund code: - FOR non-adjusted claim records for each fund code/status include the following counts: * total number header records (if claim type = A, C, I, P, Q) and total Header Paid amount * total number detail records (if claim type = B, D, L, M, O) and total Detail Paid amount - FOR adjusted claim records for each fund code/status include the following counts: * total number header records (if claim type = A, C, I, P, Q) * total number detail records (if claim type = B, D, L, M, O) The Vendor shall report discrepancies between control totals and corresponding Approved to Pay Totals and initiate research within one (1) day. The Vendor shall provide the cause of the discrepancy and solution options to the Agency within ten (10) days of the corresponding checkwrite in which the discrepancy occurs. Discrepancies identified above shall not disrupt the transmission of data files to the Agency and/or other vendors unless directed otherwise by the Agency.

New #	Claims Requirements
3.06.033	The Vendor shall prescreen hard-copy claims before entering into the system, and return those not meeting certain Agency defined criteria within five (5) days of receipt. Prescreening elements will include: - provider identification; - recipient identification; - provider signature; and - appropriateness of the claim form. The Vendor shall identify all prescreening problems before returning the claim to the provider and maintain copies of claims for audit purposes. Returned paper claims must receive an internal control number (ICN) be imaged and accompanied by an explanation as to the reason for the return. The Vendor shall maintain an on-line daily log of claims, with the ICN number assigned, which are returned to providers.
3.06.034	The Vendor shall verify that all encounter and FFS claims (hard-copy and electronic) were accepted into the system for processing.
3.06.035	The Vendor shall identify any activated claim batches that fail to balance to control counts and notify the transmitter and the Agency within one (1) day.
3.06.036	The Vendor shall maintain an adequately staffed data entry unit to enter paper claims into the MMIS within the following time guidelines: - Claims with attachments within five (5) days - Claims without attachments within ten (10) days
3.06.037	The Vendor shall perform data entry of all hard-copy claims and claim-related documents with appropriate quality assurance controls approved by the Agency.
3.06.038	The Vendor shall process electronic claim adjustments on-line real-time and enter and process paper claim adjustments within ten (10) days of receipt.
3.06.039	The Vendor shall edit all data entered into the system (hard-copy and electronic) and perform required presence and valid format editing on claims at the time of entry.
3.06.040	The Vendor shall report to the Agency all claim adjustments resulting from Vendor processing errors within one (1) day of identifying the error. The Vendor shall provide the cause of the error and solution options to the Agency within ten (10) days of the corresponding checkwrite in which the error occurs.
3.06.041	The Vendor shall perform on-line real-time validity editing on all hard copy claims against provider, recipient, reference, and other MMIS data
3.06.042	The Vendor shall meet or exceed claim payment standards for "clean" claims set by the Agency or the federal government, for each claim type
3.06.043	The Vendor shall maintain on-line real-time capability to search sixty (60) months of claims, adjustments, and financial transactions. The search capability shall include but not be limited to recipient ID, provider ID, control number, claim data and claim status.
3.06.044	The Vendor shall maintain an on-line real-time claims control and inventory system as approved by the Agency.

New #	Claims Requirements
3.06.045	The Vendor shall print, stock, and distribute all Agency approved specific claims and authorization forms and distribute to providers and health plans at no charge. The forms shall include but not be limited to: - Pharmacy claim form (Agency unique) - Crossover Form 340 Professional Medicaid/Medicare Related Claim
3.06.046	The Vendor shall make available and provide on-line in COLD: claim copies, adjustments, refund transactions, recipient, provider, reference, and PA data and reports.
3.06.047	The Vendor shall produce and provide within one (1) day reports of claims entry statistics requested by the Agency, in an Agency approved format.
3.06.048	The Vendor shall produce claims inventory management analysis reports by claim type, processing location, and age.
3.06.049	The Vendor shall accept drug, dental, institutional and professional claim types on-line, on tape and diskette and accept drug claims on POS device. Toll-free lines shall be made available for EVS transmissions only.
3.06.050	The Vendor shall adhere to HIPAA standards for claims submission and claims remittance advice transactions, utilizing a translator as necessary for HIPAA electronic standards. The Vendor shall process ASC X12 4010 and ASC X12 5010 transactions concurrently.
3.06.051	The Vendor shall prescreen all electronic claims prior to control number assignment to ensure that, if errors are present that prevent the entire electronic submission from being entered into the system, the submission shall be returned to the provider for correction and resubmittal and the rejection notice sent within twenty-four (24) hours.
3.06.052	The Vendor shall identify, upon receipt, each electronic claim, encounter, adjustment, and financial transaction and assign an internal control number (ICN) which includes but is not limited to the date of receipt, batch number and the sequence of the claim within the batch per Alabama specifications. The Vendor shall within one (1) day of receipt, assign an ICN to paper claims, attachments and adjustment requests. The Vendor shall link claims to its attachment or adjustment and the attachment or adjustment to the corresponding claim.
3.06.053	The Vendor shall produce and output to COLD, all daily, weekly, monthly, quarterly and annual claims reports, including but not limited to: - Data entry statistics; - Claims entry statistics; and - Electronic submission.
3.06.054	The Vendor shall maintain and provide the Agency access to claims images for six (6) years for use in research.

New #	Claims Requirements
3.06.055	The Vendor shall maintain a keying accuracy rate of at least ninety-nine and eight tenths percent (99.8 %) for the following data fields on all paper claims: - Recipient name - all claims (only the first two (2) positions of the first name if the recipient number is valid). The full recipient name shall be keyed only when the recipient number is missing or invalid; - Medicaid number - all claims; - Provider name - all claims (only first two (2) positions); - Provider number - all claims; - Date of service/dispensed date/ statement covers period - all claims; - Place of service - where present; - Procedure code/drug code/revenue code - all claims; - Prior Authorization number - where present; - Third Party Amount - where present; - Quantity - all claims; and - Copay indicator - pharmacy claims.
3.06.056	The Vendor shall retain, according to a retention schedule defined by the Agency, hard-copy documents and claims on-site until the batch is fully adjudicated and until the retention period has expired.
3.06.057	The Vendor shall provide within ten (10) days batch requests for copies of claims, recipient, provider, reference and prior authorization data, including associated reports.
3.06.058	The Vendor shall load electronically submitted claims within one (1) day of receipt.
3.06.059	The Vendor shall produce, reconcile, and submit to the Agency on Tuesday following each checkwrite, transaction response time, balancing and control reports that reconcile all claims entered into the system to the batch processing cycle input and output counts.
3.06.060	The Vendor shall provide the on-line capability to verify critical fields using data entry software editing, supervisor audit verification of keyed claims, or other methods defined and/or determined acceptable by the Agency.
3.06.061	The Vendor shall provide for automated verification of key (critical) fields on tape or electronic claims. Identify claims to be rejected or excluded from processing due to less than minimum required data present.
3.06.062	The Vendor shall provide on-line real-time correction to, claims suspended as a result of data entry or provider errors
3.06.063	The Vendor shall provide on-line real-time data entry software and key verification edits, at a minimum, as defined by the current Alabama specifications.
3.06.064	The Vendor shall format, store and make available on-line claim facsimiles or optical images for all claims submitted. The Vendor shall format all claim facsimiles like hard copy claims through use of a form overlay. The Vendor shall format, store and make available on-line optical images for attachments.
3.06.065	The Vendor shall monitor, track, and maintain control over all claims, encounters, adjustments, and financial transactions from receipt to final disposition

New #	Claims Requirements
3.06.066	The Vendor shall maintain and make available upon request transaction logs for AMMIS (accurate and complete audit trail of claims entry and processing activity)
3.06.067	The Vendor shall maintain batch controls and batch audit trails for all claims and other transactions entered into the system. The Vendor shall make audit trails available to the Agency within one (1) day of request.
3.06.068	The Vendor shall edit to prevent duplicate entry of claims
3.06.069	The Vendor shall provide inventory management analysis by claim type, processing location, and age to include but not be limited to: Exception reports of claims in suspense in a particular processing location for more than an Agency specified number of days.
3.06.070	The Vendor shall interface with provider, biller, Medicare carrier, and intermediary electronic networks as applicable, which include but is not limited to: - Telecommunication links; - Personal computer transmission; - Direct interface between the MMIS and the provider; and - Updates to MMIS claims processing system.
3.06.071	The Vendor shall operate the Claims/Encounter Processing component of the MMIS, including improvements as they are implemented.
3.06.072	The Vendor shall maintain a method to process for payment "special" claims, including late billing, recipient retroactive eligibility, out-of-state emergency, payment under court order, result of an appeal/fair hearing, class action suit, and any other Agency defined situation, in accordance with Agency instructions, on an exception basis.

New #	Claims Requirements
3.06.073	The Vendor shall maintain on-line real-time and provide search capability for sixty (60) months of claims history (including pharmacy and non-pharmacy), and all claims for "lifetime procedures". This claims data shall be available to search and update the claims history file as well as to perform audit processing. The Vendor shall provide the capability to search by recipient ID, provider ID, and/or control number. Data retained should include but is not limited to: - A minimum of eight (8) diagnosis codes at the header and detail level or as mandated by HIPAA (not applicable to dental and pharmacy claims); - Multiple procedure code modifiers per line; - Billing, supervising, rendering, and referring provider for EPSDT, health department or dental at the header, with rendering and referring provider maintained at the detail level for professional and dental claims, and the ability to suspend at the detail level; - Recipient name and ID; - Provider name and ID; - Medicare and TPL denial reason codes or indicators; - A minimum of ten (10) error codes at the detail level and ten (10) additional error codes at the header level or as mandated by HIPAA; - Billed, allowed, and paid amounts; - Deductible, coinsurance amounts, if any, and Medicare payment or denial dates; - Recipient Medicaid copayments and LTC patient liability, as applicable; - TPL amounts, TPL input/output codes to reflect TPL editing, outcomes (e.g., no coverage, rejection submitted), if any, and TPL payment or denial dates; - Procedure, drug, or other service codes, including revenue codes and procedure code modifiers; - EPSDT, pregnancy, family planning, and emergency services; - Pricing action code; - Date(s) of service, date of adjudication, and date of payment; and - Late bill override codes.
3.06.074	The Vendor shall store and display all reference indicators and other claim data elements as they are submitted on the claim by the provider. The Vendor shall accept and maintain these elements throughout AMMIS including claims history. Elements should include but not be limited to: - all TPL-related claim data including third party identifying information; * diagnosis codes indicating trauma, * TPL payment/denial indicators (TPL Input/Output Codes), * Insurance Company and policy identifiers (including policy and group numbers) * coordination of benefits (COB) data: * claim override codes; * NCPDP other coverage payment and denial codes.
3.06.075	The Vendor shall perform all data processing operations to support Claims/Encounter processing requirements, including: - On-line real-time Edit/Audit processing including Correct Coding Initiatives (CCI) Edits; - Suspense resolution; - On-line real-time Claim pricing; and - On-line real-time Adjudication processing.

New #	Claims Requirements
3.06.076	The Vendor shall conduct weekly meetings to discuss claims issues and resolution which my include developing new edits and audits, updating the claims resolution instructions, or resolving claims issues in accordance with program policy and procedures.
3.06.077	The Vendor shall maintain an adequately staffed claims/encounters resolution unit to resolve claims suspended for edits and audits designated by the Agency. The Vendor shall resolve **all claims suspended** within ninety (90) days of receipt.
3.06.078	The Vendor shall manually and systematically review and resolve ninety-five percent (95%) of claims/encounters that suspend for any of the edits and/or audits **for reasons other than medical review** to pay or deny status within twenty-five (25) days of receipt and one hundred percent (100%) within ninety (90) days of receipt.
3.06.079	The Vendor shall manually and systematically review and resolve ninety-five (95%) percent of claims/encounters that suspend for any of the edits and/or audits **for medical review** to pay or deny status within sixty (60) days of receipt and one hundred percent (100%) within ninety (90) days of receipt.
3.06.080	The Vendor shall process as encounters; claims with HMO covered services for HMO recipients as directed by the Agency.
3.06.081	The Vendor shall suspend claims for those specific providers, procedure codes, or provider types placed on prepayment review by the Agency or Vendor.
3.06.082	The Vendor shall price and process all claims, encounters and other claims-related transactions in accordance with the program policy, benefits, and limitations as defined and established by the Agency. The Vendor shall include in the Financial cycle all electronic claims received by 5:00 P.M. (CST) on the day of the cycle.
3.06.083	The Vendor shall provide an on-line audit trail for all claims and adjustments from time of receipt to time of payment. Each claim record shall show each stage of processing, the date the claim was entered in each stage, any error codes posted to the claim, resolution of each error code and processor ID so a claim may be located at any time and so that all failed edits and edit dispositions can be identified.
3.06.084	The Vendor shall execute claims/encounters processing cycles and generate outputs on an Agency approved schedule, in accordance with the standards determined by the Agency.
3.06.085	The Vendor shall implement procedures to identify claims suspended as a result of data entry errors and correct such errors.
3.06.086	The Vendor shall assist providers with issues on claim denials or cutbacks in accordance with Agency approved procedures or refer to the Agency if unable to resolve.
3.06.087	The Vendor shall designate a staff person as the point of contact to coordinate the resolution of all special batch claims submitted by the Agency.
3.06.088	The Vendor shall provide adequate staffing to resolve claims requiring PAs and/or attachments, such as TPL, sterilization and abortion consent documents and Medicare attachments or medical review.

New #	Claims Requirements
3.06.089	The Vendor shall maintain adequate staff to manually price certain claims according to Agency specified criteria.
3.06.090	The Vendor shall monitor the use of override codes during the claims resolution process to identify potential abuse, based on Agency defined guidelines.
3.06.091	The Vendor shall maintain and update claims control, exception control, medical criteria, and other parameter files as required and in accordance with Agency change control procedures.
3.06.092	The Vendor shall coordinate with the Medicare contractors to facilitate testing and processing of Medicare crossover claims.
3.06.093	The Vendor shall prepare and make available reports identified in the Alabama MMIS Reports Listing located in the Procurement Library.
3.06.094	The Vendor shall transmit monthly, within five (5) days of the last checkwrite, a file of adjudicated claims and encounter records to be used by the Agency for additional reporting and research. The Vendor shall provide the file in a format approved by the Agency and will contain all fee for service and encounter claims adjudicated in the management reporting period.
3.06.095	The Vendor shall produce and submit to the Agency, on a timely basis, all required claims and encounter processing reports.
3.06.096	The Vendor shall receive and process all outpatient claims in the same format as they are submitted to Medicare. Medicare utilizes the Outpatient Prospective Payment System (OPPS) whereby providers may submit all procedure codes rendered for a date of service. This may require receiving and processing procedure codes that have a zero price. Accepting straight Medicaid claims utilizing the Medicare format will preclude providers from maintaining two (2) billing formats for outpatient claims.
3.06.097	The Vendor shall meet all federal and State Processing Requirements.
3.06.098	The Vendor shall perform on-line, real-time adjudication of claims transmitted electronically twenty-one (21) hours a day, seven (7) days a week with the down-time occurring between 2AM and 5AM.
3.06.099	The Vendor shall process claims received according to the following standards: - Ninety percent (90%) within thirty (30) calendar days of receipt, - Ninety-nine percent (99%) within ninety (90) calendar days of receipt. (Note: Processed claims are those claims adjudicated to final payment or denial status and the EFT payment has been released or the provider has been mailed a paper check.
3.06.100	The Vendor shall process provider adjustment requests and Agency initiated adjustments according to the following standards: - Ninety-five percent (95%) within thirty (30) calendar days of receipt, and - Ninety-nine percent (99%) within ninety (90) calendar days.
3.06.101	The Vendor shall process to completion all adjustments resulting from system-caused or Vendor-caused errors within twenty-five (25) calendar days of identification of the error.

New #	Claims Requirements
3.06.102	The Vendor shall process on-line real-time all edits and audits currently defined for Alabama to include but not limited to: - ensure that the services for which payment is requested are covered by the Alabama Medicaid Program. - timely filing requirements - applicability of Medicaid recipient cost sharing requirements on applicable claims - suspend claims requiring provider or recipient prepayment review. - ensure that diagnosis, revenue and procedure codes are present on Medicare crossover claims and all other appropriate claim types. - recipient eligibility on date(s) of service. - recipient Lock-in claims utilizing the on-line recipient Lock-in file. - valid recipient using recipient ID and first two (2) letters of first name. - newborn recipient eligibility based on State-defined criteria. - recipient participation in special programs against program services and restrictions. - provider eligibility, including but not limited to: editing of the provider's CLIA identification number, provider type and specialty, and provider contract to determine if the provider is allowed to render the service billed. - provider participation as a member of the billing group. - nursing facility and waiver program claims against PA or LTC file. - PA requirements and that the claim matches to an active PA on the MMIS. - prior-authorized claims and cut back billed units or dollars, as appropriate, to remaining allowed units or dollars. - perform automated cross-checks and relationship edits (including diagnosis/sex) on all claims and adjustments. - perform automated audit processing using history claims, suspended claims and same claims. - each data element of the claim record for required presence, format, consistency, reasonableness and/or allowable values. - for potential and exact duplicate claims - adjudicate pharmacy claims for payment and perform ProDUR functions on pharmacy claims.
3.06.103	The Vendor shall maintain a function to process claims against an edit/audit criteria file or table (maintained in the Reference Data Maintenance function) to provide flexibility in edit and audit processing.
3.06.104	The Vendor shall maintain a function to edit for managed care participation and restrictions. The function shall include but not be limited to evaluation of managed care criteria including claim type, provider type, provider specialty, diagnosis procedure limitations. The requirements shall all have effective and end dates. The function shall also support referral requirements to ensure restriction of recipients to receive services either from the PMP or from another qualified provider to whom the participant was referred by the PMP. The function shall also make use of specific override codes for the Maternity Care Program.
3.06.105	The Vendor shall update on-line real-time the PA record to reflect the services paid or adjusted for processed claims and to update the number of services or dollars still remaining to be used on the record.
3.06.106	The Vendor shall perform automated audits using potential duplicate and suspect duplicate criteria to validate against all other claims in the system.

New #	Claims Requirements
3.06.107	The Vendor shall edit each claim record as completely as possible during an edit or audit cycle, rather than ceasing the edit process when an edit failure is encountered. The Vendor shall post to claims history a minimum of twenty (20) edit and audit error code occurrences per claim.
3.06.108	The Vendor shall provide, for each error code, a resolution code, an override, and force or deny indicator, and the date that the error was resolved, forced, or denied; forced claims shall carry the ID of the operator to provide a complete on-line audit trail of processing.
3.06.109	The Vendor shall perform overrides of claim edits and audits in accordance with Agency approved guidelines.
3.06.110	The Vendor shall update claim history file with paid and denied claims data from each adjudication cycle.
3.06.111	The Vendor shall maintain a record of services needed for audit processing where the audit criteria covers a period longer than sixty (60) months (such as once-in-a-lifetime procedures).
3.06.112	The Vendor shall limit benefits payable by recipient eligibility category.
3.06.113	The Vendor shall maintain a function to process claims against an ESC disposition file or table (maintained in the Reference Data Maintenance function) to provide flexibility in claims dispositioning. The Vendor shall allow dispositions and exceptions to edits/audits based on bill/claim type, submission media, provider type, individual provider number, revenue, procedure or diagnosis codes. The Vendor shall provide the capability to disposition edits/audits to: (1) Pend to a specific location for correction (2) Deny with explanatory message(s) on provider remittance statement (3) Pay and report to the Contractor or to the Agency with explanatory messages (for use in postpayment activities)
3.06.114	The Vendor shall identify potential and existing third party liability (including Medicare) and deny, recoup or pay and report the claims, depending on the edit, if it is for a covered service under a third party resource, for applicable claim types and covered periods using claim data, the TPL Matrix, Recipient Policy File, and other TPL edits to identify coverage. The Vendor shall maintain edits to identify non-covered Medicare and TPL services for processing exclusions to relevant Medicare and TPL edits.
3.06.115	The Vendor shall edit to ensure that all required attachments, per the reference files or edits, have been received and maintained for audit purposes. The Vendor shall provide a method to receive attachments and input specified data into a file which can be systematically accessed when claims are submitted for payment.
3.06.116	The Vendor shall identify the allowable reimbursement for claims according to the date-specific pricing data and reimbursement methodologies contained on applicable Provider or Reference files for the date of service on the claim.
3.06.117	The Vendor shall price Medicare coinsurance or deductible crossover claims at the lower of the Medicaid or Medicare allowed amount, full coinsurance and deductible, at a unique QMB rate, or other payment methodologies as determined by the Agency, depending on recipient

New #	Claims Requirements
	program eligibility or type of claim.
3.06.118	The Vendor shall price services billed with procedure codes with multiple modifiers.
3.06.119	The Vendor shall price claims according to the policies of the program the recipient is enrolled in at the time of service and edit for concurrent program enrollment.
3.06.120	The Vendor shall edit billed charges for reasonableness and flag any exceptions, including the ability to vary the parameters of this edit by provider type, claim type, and edit disposition.
3.06.121	The Vendor shall identify and calculate payment amounts according to the fee schedules, per diems, capitation rates, and global rates established by the Agency.
3.06.122	The Vendor shall price encounter "claims" with a calculated payment amount and maintain amount in record, but authorize zero payment to the provider.
3.06.123	The Vendor shall deduct patient liability amounts when pricing long-term care claims including nursing home and hospice claims or as otherwise specified by the Agency.
3.06.124	The Vendor shall deduct TPL and Medicare paid amounts, as appropriate, when pricing claims
3.06.125	The Vendor shall deduct recipient co-payment amounts, as appropriate, when pricing claims.
3.06.126	The Vendor shall maintain flexibility and adequate staffing to accommodate individual consideration for pricing miscellaneous procedures, unpriced procedures and services not ordinarily covered by Medicaid but which must be paid for EPSDT or other programs.
3.06.127	The Vendor shall price different provider groups with different amounts using the same procedure codes.
3.06.128	The Vendor shall provide a process to link the retrieval of the image of a suspended paper claim document to the suspended claim record.
3.06.129	The Vendor shall provide the capability for selected Vendor or Agency staff to perform a force or override on an error code based on individual operator IDs or authorization level.
3.06.130	The Vendor shall maintain the original billed amount, calculated allowed amount, an indication of the pricing method used to determine the payment amount, any manually priced amount, and the final reimbursement amount on the claim history record.
3.06.131	The Vendor shall provide the capability to determine what the payment amount would have been used for encounter claims and apply TPL logic.
3.06.132	The Vendor shall provide on-line, real-time claims suspense resolution capabilities for all claim types.
3.06.133	The Vendor shall maintain on-line real-time claim correction screens which display all claims data as entered or subsequently corrected.
3.06.134	The Vendor shall completely reprocess corrected claims and all edits and audits are reprocessed.

New #	Claims Requirements
3.06.135	The Vendor shall maintain on-line real-time search and update capability to claim correction screens with access by internal control number, provider ID, recipient ID, and/or claim location.
3.06.136	The Vendor shall provide search capability for the status of any related limitations for which the recipient has had services such as the number of office visits paid per year
3.06.137	The Vendor shall assign a unique status and clerk identification to corrected suspense claims.
3.06.138	The Vendor shall maintain all claims on the suspense file until corrected, automatically recycled, or automatically denied.
3.06.139	The Vendor shall Interface with an Agency specified contractor, currently HID (Health Information Design), to process electronic PA requests in real-time mode for pharmacy claims, using the NCPDP P4 request/response transaction.
3.06.140	The Vendor shall process a file of claim information from an Agency specified vendor or SUR. The Vendor shall update history with the file indicating the claim has been recouped and cannot be adjusted.
3.06.141	The Vendor shall create a pharmacy claim extract (both paid and voided claims) on a daily basis along with a change extract (when a recipient's SSN is changed) and transmit it to the vendor specified by the Agency.
3.06.142	The Vendor shall provide the ability to include the Preferred Drug list (PDL) edit in the pharmacy claims processing.
3.06.143	The Vendor shall run a test submission on electronic and tape billings to ensure that the submission format is accepted by the Alabama MMIS, prior to approving agreements with automated billing service vendors.
3.06.144	The Vendor shall develop and implement a testing process for providers who wish to begin submitting electronic media claims to ensure provider compliance before allowing EMC transmission.
3.06.145	The Vendor shall provide a report on a quarterly basis that identifies exact duplicate claims. The report should be placed on COLD the first day of each quarter.
3.06.146	The Vendor shall provide reports on a monthly basis that identify recipients who have exceeded specified benefit limitations by prior calendar year and current calendar year. The reports should be placed on COLD the last day of each month.
3.06.147	The Vendor shall maintain a history of all pricing data to support the claims that are maintained.
3.06.148	The Vendor shall maintain system edits to recognize and deny pharmacy claims for dispensing of inappropriate number of units. The edits shall recognize minimum and maximum units based on monthly refills.

3.07 Financial Requirements

The Claims Reporting and Financial function provides the overall support and reporting for all of the claims processing and financial activities necessary to support the Alabama Medicaid Program. It includes processing for claim payments, adjustments, refunds, accounts receivables and other financial transactions such as voids, credits, returned checks, manual checks, cash receipts, repayments, recoupments, cost settlements and non-claim-related system payments (payouts). This function ensures that all State funds are appropriately disbursed and that all transactions are applied accurately.

Among the processes that the Financial Processing function includes is generation of payments to providers and the production of a remittance advice for each provider who has had claims adjudicated and/or financial transactions processed. The payments can take the form of check or an EFT.

Financial Functions:

- ***Payment Processing*** - AMMIS has the ability to generate payments for payees of varying types for various reasons. The primary payee is a provider. The primary payment reason is claims but payments are also made for expenditures (payouts) and capitated payments. The provider has two primary methods of receiving payment from the AMMIS, check or electronic funds transfer (EFT). Payments are generated in the financial batch cycle. The AMMIS financial system produces a remittance advice that provides a detailed explanation of the transactions that resulted in payment(s) or other financial activity each financial cycle.

- ***Scheduling*** - Scheduling has two functions:

    - Determine payers and the types of claim and financial transactions to process in a financial cycle based on established financial schedules.

    - Determine the specific claim and financial transactions to bring into the financial cycle based on payers, claims and financial transactions specified in the schedule.

- ***Remittance Advice (RA)*** - The Remittance Advice (RA) is the primary document sent to a provider that reports claim activity, claim status, payments sent to and monies received from a provider. Providers can request to receive only an electronic RA, only paper or both. The RA is generated in each claims payment cycle. A provider will only receive a RA if the provider has activity during the claim payment cycle.

- ***IRS reporting (1099/W2)*** - Annual earnings, based on the unique Tax Identification Number (TIN), are reported on IRS Form 1099 and submitted to each provider and the Internal Revenue Service and the Alabama Department of Revenue. All money earned by TIN is reported on the Form 1099.

The following are the requirements identified by the Agency that must be met by the Vendor to support the successful operation of the Claims Financial related functions.

New #	Financial Requirements
3.07.001	The Vendor shall process and generate incentive payments to primary care providers, upon request within ten (10) days or in the next check write.
3.07.002	The Vendor shall update the claims history file/database with the check number, financial cycle date, and amount paid information by the first day following each financial cycle.
3.07.003	The Vendor shall prevent processing of checks and EFTs for those test transactions processed through the Integrated Test Facility.
3.07.004	The Vendor shall perform all internal balancing activities to ensure accurate disbursement of payments.
3.07.005	The Vendor shall provide on-line real-time access to claims and financial information.
3.07.006	The Vendor shall provide on-line user manual to instruct Agency staff on accessing claims and financial information. The Vendor shall maintain the on-line user manual to reflect current system functions. The Vendor shall provide hands-on user training for a minimum of twenty-four (24) Agency staff monthly or as requested by the Agency.
3.07.007	The Vendor shall provide on-line and in COLD payment data from the provider claims, adjustments, accounts receivable, and transaction processing activities to the Agency. Provide access to payment data within one (1) day of the checkwrite.
3.07.008	The Vendor shall support all claims reporting functions, files, and data elements necessary to meet the requirements of this ITB.
3.07.009	The Vendor shall provide systematic update capabilities to claims and financial history.
3.07.010	The Vendor shall utilize EFT to deposit payments to provider accounts.
3.07.011	The Vendor shall identify all checks to be pulled for stop payment.
3.07.012	The Vendor shall receive and process all returned provider checks.
3.07.013	The Vendor shall review provider 1099 earnings reports and resolve any discrepancies before mailing or within five (5) days of being notified of a discrepancy.
3.07.014	The Vendor shall support all financial application functions, files, and data elements to meet all requirements in the ITB.
3.07.015	The Vendor shall establish the capability to split-release provider payments as directed by the Agency.

New #	Financial Requirements
3.07.016	The Vendor shall provide to Medicaid, two (2) months prior to Operations, a detailed allocation by cost centers for Vendor activities on which percentages of the administrative fees are allocable at ninety percent (90%), at seventy-five percent (75%), and at fifty percent (50%) federal financial participation. Such allocation shall be in accordance with the requirements of federal regulations for Alabama MMIS, Section 11276 in Part 11 of the State Medicaid Manual and in a manner prescribed by the Agency.
3.07.017	The Vendor shall complete the payment cycles on an Agency approved schedule to ensure provider payments and remittance advices can be electronically transmitted or mailed. Electronic remittances (835) must be transmitted within one (1) day following the checkwrite. Paper remittances must be mailed within five (5) days following the checkwrite or upon release of the provider's payment.
3.07.018	The Vendor shall process and generate capitation payments for HMO and managed care providers as part of the normal financial cycle.
3.07.019	The Vendor shall process and generate case management fees for the PCCM Program and the Recipient Lock-In Program as part of the normal financial cycle when requested by the Agency.
3.07.020	The Vendor shall process and generate HIPP payments weekly.
3.07.021	The Vendor shall produce and submit to the Agency all required financial reports no later than the first day following the financial cycle.
3.07.022	The Vendor shall generate, image, and make available on-line remittance advices by the first day following each check write.
3.07.023	The Vendor shall generate recipient history printouts within one (1) day of receipt of requests.
3.07.024	The Vendor shall enter provider refunds information into the cash receipts panel within two (2) days of receipt. The Vendor shall process the refund through the claims system within fifteen (15) days of receipt.
3.07.025	The Vendor shall ensure the percentage of EFT payments to total payments per payment cycle must remain above ninety-five percent (95%) of total dollars as specified in the Cash Management Improvement Act of 1990.
3.07.026	The Vendor shall produce and transmit a monthly paid claims extract file to the Agency and designated contractors within ten (10) days of the last payment processing cycle of the month.
3.07.027	The Vendor shall produce and mail (or transmit electronically) provider 1099 earnings reports to providers no later than January 31, each year. Reports shall represent the total net payments to the provider. The Vendor shall reissue any 1099's which are found to be in error within five (5) days of request.
3.07.028	The Vendor shall provide the Agency a copy of the final provider 1099 earnings reports no later than January 31 of each year.

New #	Financial Requirements
3.07.029	The Vendor shall produce and mail (or transmit electronically) federal and state 1099 tapes in accordance with federal and state regulations no later than January 31, each year. The Vendor shall reissue any 1099's which are found to be in error within five (5) days of request.
3.07.030	The Vendor shall produce and make available online reports on accounts receivable collections and outstanding balances in aggregate and/or individual accounts within one (1) day following check write.
3.07.031	The Vendor shall process adjustments entered on-line and reflect the change in the next financial cycle.
3.07.032	The Vendor shall process all Agency approved mass adjustments in the next financial payment cycle.
3.07.033	The Vendor shall provide copies of bank statements and reconciliations for each bank account maintained on behalf of the Agency no later than twenty-five (25) calendar days following the end of each month.
3.07.034	The Vendor shall produce and submit to the Agency the electronic transmittal of invoices, in a format established by the Agency, no later than 10:00 a.m. central time on the first day following the financial cycle. If the Vendor, for any reason, makes payment to a provider for an amount different from that shown on the register, the Agency shall be notified immediately of the change and the reason thereof.
3.07.035	The Vendor shall provide to the Agency no later than ten (10) calendar days following the end of the month checks due to the Agency from all accounts maintained on behalf of the Agency. The Vendor shall ensure that refunds and un-cashed checks are accompanied by a summary of the account activity broken down by fund code. Interest shall be identified by each account.
3.07.036	The Vendor shall create accounts receivable records and produce and mail (or submit electronically) third party invoices on a schedule approved by the Agency. The Vendor shall prior to creation of accounts receivable: Within two (2) days of the end of each month, create pre-production reports for review by Agency staff and make available in COLD. Within two (2) days of Agency approval of pre-production reports, vendor shall produce paper and electronic billings and mail/transmit post-payment billings. Invoices shall not be added to accounts receivable or distributed prior to Agency approval. Pre-production reports, accounts receivable entries, and claims facsimiles (or hard copy claim facsimiles) shall be available for on-line viewing.

New #	Financial Requirements
3.07.037	The Vendor shall process monies received from providers for services paid for recipients retroactively determined to be ineligible, SUR recoupments, returned checks, provider checks and any other checks received. Checks from third party payers will be forwarded to the Agency for processing within three (3) days of receipt.
3.07.038	The Vendor shall perform two (2) provider payment cycles per month or on a schedule established by the Agency.
3.07.039	The Vendor shall maintain payment mechanisms to providers, to include identification of check generation and electronic funds transfer (EFT).
3.07.040	The Vendor shall suppress the generation of zero-paid checks but shall generate associated remittance advices.
3.07.041	The Vendor shall maintain the capability to print informational messages on remittance advices, with multiple messages available on a user-maintainable message text file, with selectable print parameters such as provider type, claim type, and payment cycle date(s).
3.07.042	The Vendor shall update provider payment data and 1099 data on the Provider data set.
3.07.043	The Vendor shall maintain provider accounts receivable and deduct appropriate amounts from payments due after each claims financial processing cycle.
3.07.044	The Vendor shall maintain a process to set payment schedules and delay payment issuance, as determined and approved the Agency, including the ability to limit payments to specified dollar limits.
3.07.045	The Vendor shall generate and distribute provider remittance advices (RA) in electronic (electronic transmissions will have to conform to ASC X12N 835 and/or ASC X12N 277 Unsolicited format) or hard-copy media, and on-line access for EDS and Agency staff (COLD), to include the following information: - A separate itemization of submitted claims, by claim type, that were paid, denied, or adjusted, and any financial transactions that were processed for that provider, including subtotals and totals; - Post capitation payment, as required, with supporting detailed documentation. - An itemization of suspended claims; - Adjusted claim information showing both the original claim information and the adjusted information, with an explanation of the adjustment reason code; - The name and address of the insurance company or companies; - Medicare carrier or Health Plan, the name of the insured, and the policy and group number for claims rejected due to TPL coverage on file for the recipient; - Explanatory messages relating to the claim payment cutback or denial; - Summary section containing earnings information regarding the number of claims paid, denied, suspended, adjusted, and in process; and financial transactions for the current payment period, and year-to-date; - Up to ten (10) EOB messages per claim header and per claim detail or as mandated by HIPAA.; and - Provider demographics to include but not limited to: provider NPI, address information, and service location.

New #	Financial Requirements
3.07.046	The Vendor shall post EOB messages applicable to the claim history record.
3.07.047	The Vendor shall provide electronic RAs on the Web for provider download within one (1) day following a checkwrite. All electronic claim submissions will receive an 835 electronic remittance advice.
3.07.048	The Vendor shall produce RAs in multiple formats and content for paper RAs for different claim types such as hospital, pharmacy, professional, and LTC. All formats must be approved by the Agency.
3.07.049	The Vendor shall maintain complete audit trails of adjustment processing activities on the claims history files.
3.07.050	The Vendor shall maintain the ability to adjust units and dollars on the Prior Authorization Records to reflect credit and repayment transactions.
3.07.051	The Vendor shall maintain a process to allow on-line changes to the adjustment claim record to reflect corrections or changes to information during the claim correction (suspense resolution) process.
3.07.052	The Vendor shall accept and process HIPAA compliant provider-submitted electronic adjustment and void requests.
3.07.053	The Vendor shall maintain a process to omit Agency identified adjustments from the provider's RA such as but not limited to recipient reKeys.
3.07.054	The Vendor shall maintain an automated mass-adjustment function to: - accept mass adjustment criteria electronically, - reprocess claims for retroactive pricing changes, - reprocess claims for recipient eligibility changes, - reprocess claims for provider eligibility changes, - and other changes necessitating reprocessing of multiple claims. The Vendor shall process adjustments within Agency specified timeframe upon request.
3.07.055	The Vendor shall maintain a non-claim specific adjustment function to make a payment or a debit on a provider without relating it to a claim such as but not limited to lump sum recoupments or payments.
3.07.056	The Vendor shall maintain an on-line mass-adjustment selection screen, limited to select users, to enter selection parameters including but not limited to: time period, provider number(s), provider type, provider specialty, provider location, recipient number(s), age (min/max), gender, aid category, claim type(s), region code, revenue code, procedure and modifier(s), diagnosis code, NDC, error status code (ESC), and health program. Any claims meeting the selection criteria will be displayed for review and will have the capability to select or unselect chosen claims for continued adjustment processing.

New #	Financial Requirements
3.07.057	The Vendor shall maintain a retroactive rate adjustment capability which will automatically identify all claims affected by the adjustment, create adjustment records for them, reprocess them, and maintain a link between the original and adjusted claim and complete within Agency specified timeframe upon request. This process shall be considered routine maintenance and will not require a Customer Service Request.
3.07.058	The Vendor shall update claims history and financial information with all appropriate financial records and adjustments. All reporting shall reflect this information.
3.07.059	The Vendor shall update claims history and financial information to reflect TPL claim-specific recoveries. All reporting shall reflect this information.
3.07.060	The Vendor shall prevent multiple adjustments to a single claim record; apply successive adjustments to the most current version of the claim.
3.07.061	The Vendor shall maintain the capability to report all adjustment transactions by the fund code and State category of service.
3.07.062	The Vendor shall retroactively reprocess nursing facility claims to identify and correct any erroneous payments resulting from changes in patient liabilities or individual nursing facility rates. The Vendor shall generate a report - Retro Adjustments due to Patient Liability Changes (CLM-0050-L) and submit to the Agency on a quarterly basis.
3.07.063	The Vendor system shall provide the capability to identify the claim to be adjusted, allow an on-line real-time change to the contents of the field to be adjusted and generate the complete adjustment transaction without requiring additional data.
3.07.064	The Vendor system shall maintain the original claim and the results of adjustment transactions in claims history; link all claims and subsequent adjustments by a cross-referencing control number. Cross- reference ICN shall appear on the original claim and the adjustment claim.
3.07.065	The Vendor system shall allow on-line real-time entry of adjustments to adjudicated claims. Adjustments shall process in the next adjudication cycle.
3.07.066	The Vendor system shall process adjustments as standard claims to include editing, pricing, auditing, and checking for duplication against other regular and adjusted claims.
3.07.067	The Vendor system shall maintain an adjustment reason code which indicates the reason for the adjustment (e.g., post payment recovery due to TPL) and the disposition of the claim (additional payment, recovery, history only, etc.) for use in reporting the adjustment.
3.07.068	The Vendor system shall have the capability to identify and allow updating of partial recoveries of Medicaid payment due to TPL.

New #	Financial Requirements
3.07.069	The Vendor shall maintain on-line real-time access and update capability to an accounts receivable file which processes and reports financial transactions by type of transaction, and provider. The file, at a minimum, must include: - Provider number; - Account balance; - Percent or dollar amount to be withheld from future payments; - Reason indicator; - Type of collection; - Authorizing party; - Due date for recoupment; - Program and authorizing Agency to be charged; - Lien holder and amount of lien; and - 1099 adjustment indicator.
3.07.070	The Vendor system shall accommodate manually issued payments and/or recoupments. The system shall update the specific provider's account to adjust the provider's 1099 earnings data.
3.07.071	The Vendor system shall accommodate the issuance and tracking of non-provider-specific payments through the MMIS (e.g., refund of an insurance company overpayment) and adjust all reporting appropriately.
3.07.072	The Vendor shall maintain assignment information (debt payment information) for garnishments and tax levies. The Vendor shall use this information in directing payments as specified in the court order or splitting payments to the provider and court ordered designee.
3.07.073	The Vendor shall generate within one (1) day after each checkwrite, a report of providers with credit balances. The Vendor shall ensure that all payments have been applied to the provider account before the report is produced.
3.07.074	The Vendor shall provide a UI panel that will display provider credit balances. The panel shall be accessible by AR number, Provider id (payee), payee type, reason code, status, effective date from, effective date to and/or fund code.
3.07.075	The Vendor shall maintain the current provider check write (payroll) information plus the previous sixty (60) months on-line. All data is currently being kept. If the data is limited to sixty (60) months a purge process must be documented and approved by the Agency before any purges occur.
3.07.076	The Vendor shall generate overpayment (credit balance) letters to providers when establishing accounts receivable. The letter is appended to the RA and will be included until the credit balance is zero.
3.07.077	The Vendor shall maintain cash management techniques (such as zero-balance bank accounts) which meet the requirements of the federal Cash Management Improvement Act of 1990 and the State of Alabama.
3.07.078	The Vendor shall process claim-specific and mass adjustment to providers as requested by the Agency and within ten (10) days of request.

New #	Financial Requirements
3.07.079	The Vendor shall maintain sufficient controls to track each financial transaction, balance each batch, and maintain appropriate audit trails on the claims history file. The Vendor shall archive financial transactions within one (1) day of each and every check write. Maintain a minimum of sixty (60) months of financial transactions in archive.
3.07.080	Within five (5) days of receipt, the Vendor shall accept returned checks and void the provider payment by automatically reversing all transactions associated with the payment, including claim payments, claim credits, and other financial transactions.
3.07.081	The Vendor shall apply lump sum recoupments to payee (group provider number) for collection within ten (10) days of receipt of the letter.
3.07.082	The Vendor shall apply the generated check numbers to the associated claims paid in the MMIS at the time the payments are generated.
3.07.083	The Vendor shall maintain on-line real-time search capabilities for financial information based on user defined criteria.
3.07.084	The Vendor shall maintain on-line inquiry to financial information with access by provider ID, it shall include, but not be limited to: - Overpayment information; - Receivable account balance and established date; - Percentages and/or dollar amounts to be deducted from payments; - Type of collections made and date; and - Both financial transactions (non-claim-specific) and adjustments (claim-specific).
3.07.085	The Vendor shall maintain an on-line real-time recoupment process that systematically creates a provider AR that can be either automatically recouped from claims payments or satisfied by repayments from the provider. The provider AR will be created any time the provider account balance is below zero.
3.07.086	At the Agency's direction, the Vendor shall accept manual or automated transactions (as input) to be recorded and reported as medical expenditures that have been processed and paid outside of the MMIS. The Vendor shall generate an invoice to the Agency for the total amount the next day. The Agency will supply the funds to the Vendor. The Vendor shall mail the payments and post the information to the MMIS within five (5) days of receipt of the funds.
3.07.087	The Vendor shall maintain a process to apply monies received toward the accounts receivable file. The Vendor shall retain a copy of the payment information including but not limited to the RA date, number, and amount. The Vendor shall apply the payment information into the provider's account within ten (10) calendar days.
3.07.088	The Vendor shall apply a fund code and state category of service provided by the Agency to all lump-sum payments at time of posting.
3.07.089	The Vendor shall apply a fund code and state category of service from the associated claims to all refunds payments at time of posting.

New #	Financial Requirements
3.07.090	The first working day after each checkwrite, the Vendor shall generate edit/audit override analysis by claim type, edit/audit, and operator ID. This report shall be available in COLD.
3.07.091	The first working day after each checkwrite, the Vendor shall generate processing cycle time analysis by claim type, input media, and provider type. This report shall be available in COLD.
3.07.092	The Vendor shall produce user-requested ad hoc reports from claim information with two (2) days of request.
3.07.093	The Vendor shall provide monthly claims and financial files in formats suitable for downloading to State computers within five (5) days of the last checkwrite of the month. Files shall include paid and denied claims, encounter claims, adjustments, capitation, and other payments and financial transactions.
3.07.094	The Vendor shall by the 5th day of the month generate a report of range of recoupments by amount and time period for providers. The report shall be available on COLD.
3.07.095	The Vendor shall provide a report, by type of media, receipts and adjudication of claims received and processed to a finalized status on a daily basis. The report shall be available on COLD.
3.07.096	The Vendor shall generate a report of cash receipts and returned funds the first working day after each checkwrite. The report shall be stored in COLD.
3.07.097	After each check write, the Vendor shall generate a report of provider accounts receivable set-up during the checkwrite period. The report shall be available the first working day after each checkwrite and shall be stored in COLD.
3.07.098	After each checkwrite the Vendor shall generate check registers and store the information in COLD. The report shall be available the first day after each checkwrite.
3.07.099	The Vendor shall by the 5th day of the month generate a report which identifies and segregates claim-specific and non-claim-specific adjustments by type of transaction (payout, recoupment, or refund) and provider type. The report shall be stored in COLD.
3.07.100	The Vendor shall by the 5th day of the month generate claims inventory trend reports. The report will be stored in COLD.
3.07.101	After each checkwrite the Vendor shall generate a report of claims and payments information. The report shall be available the first day after each checkwrite and shall be stored in COLD.
3.07.102	After each checkwrite, the Vendor shall generate a report of finalized claims, tapes, and EMC transmissions input into the payment cycle. The report shall be available the first day after each checkwrite and shall be stored in COLD.
3.07.103	After each checkwrite, the Vendor shall generate a report of error code analysis by claim type, provider, and/or input media. The report shall be available the first day after each checkwrite and shall be stored in COLD.

New #	Financial Requirements
3.07.104	The Vendor shall support on-line real-time inquiries and searches using multiple and variable user-entered selection parameters, including but not limited to: - recipient name; - recipient number; - provider name; - provider number; - service date ranges; - payment date ranges; - claim type; - claim status; - payee number; - internal control number (ICN); and - other parameters defined during the design phase.
3.07.105	The Vendor shall archive electronically in their entirety and retain permanently, all claims being purged from active claims history.
3.07.106	The Vendor shall maintain a record of any services that, due to Agency policy, are required for processing for a longer span of time than that covered by the active claims history (such as once-in-a-lifetime procedures) on active claims history for audit processing.
3.07.107	The Vendor shall provide on-line real-time search capability for non-claim-specific financial transactions.
3.07.108	The Vendor shall produce all required financial/fiscal management operations reports, and make available in COLD or deliver to Medicaid within the Agency defined timeframes.
3.07.109	The Vendor shall generate special targeted REOMBs and cover letters to be sent to recipients based on Agency criteria specified in an Agency request. The Vendor shall prepare a cover letter for each requested targeted REOMB specific to information given by the requestor. Targeted REOMBs are to be mailed promptly, but in no case shall the delay exceed ten (10) days from the REOMBs requested date. Targeted REOMBs shall be returned to the Vendor using an enclosed postage paid envelope. The Vendor shall return to the requesting Agency individual a copy of the REOMBs mailing list upon completion of the mailing.
3.07.110	The Vendor shall receive returned REOMBs at a separate post office box used specifically for the receipt of such REOMBs. The Vendor shall date and timestamp each REOMB with the date the Vendor received the REOMB. The Vendor shall sort and return REOMB responses to program areas that requested the REOMBs within two (2) days of receipt.
3.07.111	The Vendor shall produce the RAs in the format approved by the Agency within one (1) day following a checkwrite. The RA shall be clear and in a readable format, such that the information is easily located and interpreted by the user. The Vendor shall ensure RAs are available in COLD within one (1) day following a checkwrite.
3.07.112	The Vendor shall print all claims text and data information on the paper RA in a format which is understandable to providers.

New #	Financial Requirements
3.07.113	The Vendor shall review a sample of RAs after each checkwrite to ensure correctness prior to mailing to providers. The Vendor shall mail RAs to providers within five (5) days following a checkwrite except to those providers receiving a paper check, in which case the RA will be mailed when the check is released.
3.07.114	The Vendor shall capture and store a minimum of sixty (60) months of 1099 data.
3.07.115	The Vendor shall respond to provider inquiries regarding 1099 discrepancies within two (2) days with an answer to the inquiry or an estimated time required to resolve the discrepancy.
3.07.116	The Vendor shall establish and maintain a separate depository account for the receipt of funds from the Agency for provider payments. As warrants are presented for payment or electronic fund transfers are made, the Vendor shall ensure that funds are transferred from the Depository Account to the Disbursement Account. Remaining funds shall be invested in standard overnight repurchase agreements. The Vendor shall furnish the necessary bank information to accommodate federal requirements for sharing interest on undistributed funds. All bank charges on this account shall be the responsibility of the Vendor.
3.07.117	Submit on a monthly basis by the 10th of the month, a full reconciliation of all bank accounts maintained on behalf of the Agency. For the **disbursement account** the Vendor shall provide at a minimum: - A copy of the statement from the bank; - A reconciliation showing deposits and disbursements which includes voids, stop payments, manual check issues, and ACH returns; - A reconciliation to include an analysis of the account, listing in numerical sequence all checks/EFT transactions issued; - Provide a daily account analysis indicating the ledger and collected cash balances in the account on each day during the month; and - A printout from the bank to include checks/EFT that have been paid, voided, canceled or are still outstanding. For the **refund account** the Vendor shall provide at a minimum: - A copy of the statement from the bank; and - A reconciliation to include an analysis of the deposits, processed refunds, refunds over three (3) months that processed and outstanding unprocessed refunds.
3.07.118	The Vendor shall establish and maintain a separate disbursement account for the purpose of paying Medicaid providers. All bank charges to this account shall be the responsibility of the Vendor.
3.07.119	The Vendor shall establish and maintain a separate interest bearing account for deposit of refunds from Medicaid providers. All deposits to and interest earned on this account shall accrue to and be paid to the Agency no later than the tenth day of the following month. All bank charges on this account shall be the responsibility of the Vendor.

New #	Financial Requirements
3.07.120	The Vendor shall establish and maintain a separate account for the purpose of paying HIPP payments. All bank charges to this account shall be the responsibility of the Vendor.
3.07.121	The Vendor shall prepare a solicitation for bids for banking services to be approved by the Agency. Solicit bids from Alabama banks with net assets over one billion dollars ($1,000,000,000) to determine the best possible interest arrangement for Medicaid funds. The Vendor shall select the bank which offers the highest overall return on accounts and obtain Agency approval of said arrangements. The Vendor shall finalize banking arrangements no later than one (1) calendar month prior to operations.
3.07.122	The Vendor shall pay providers by electronic funds transfer (EFT). The Vendor shall deliver to their bank the necessary EFT tape(s) or electronic file(s) to cover all or any portion of the provider payroll, as directed by the Agency, for the timely release of funds. Release all EFT provider payments the day the funds are received from the Agency and all paper checks within twenty-four (24) hours of receipt of funds from Medicaid unless otherwise directed.
3.07.123	The Vendor shall provide on a monthly basis four (4) hard copies of the administrative fee invoice to include one (1) with original signature.
3.07.124	The Vendor shall generate an EFT/manual check register and a report detailing payments issued from the disbursement account for the current month. These reports shall be available in COLD the first working day after the last check write of the month.
3.07.125	The Vendor shall void all financial transactions that have not been processed within sixty (60) calendar days after the date of check or EFT. The Vendor shall, by the tenth day of the month, generate and store in COLD a monthly listing of all transactions voided for the previous month. The funds from these voids that are not reissued shall be returned to the Agency by the tenth day of the following month.
3.07.126	The Vendor shall link Accounts Receivable transactions for Medicaid providers to the corresponding claims in the MMIS and process adjustment transactions, where appropriate.
3.07.127	The vendor shall generate an aged accounts receivable report the first working day after each checkwrite for every provider with an outstanding accounts receivables. The report shall be stored in COLD.
3.07.128	The Vendor shall process cost settlement and recovery requests received from the Agency within ten (10) days.
3.07.129	The Vendor shall enter accounts receivable transactions into the MMIS Claims History within ten (10) days of Agency request.
3.07.130	The Vendor shall provide on-line real-time access for the Agency to post payments to the accounts receivable subsystem.
3.07.131	The Vendor shall update provider accounts receivable balances after every provider payroll.
3.07.132	The Vendor shall generate accounts receivable balance reports in aggregate on-line and on paper the first day after each checkwrite.

New #	Financial Requirements
3.07.133	The Vendor shall receive an account receivable memo from the Agency. The vendor shall post the amount from the memo to the providers account within ten (10) calendar days of receipt. The Vendor shall refund any excess funds in the next checkwrite.
3.07.134	The Vendor shall maintain outstanding provider accounts receivable to meet state and federal guidelines. The Vendor shall append an accounts receivable memo to the bottom of the RA. The Vendor shall apply recoveries or write-off transactions where appropriate, and report the outstanding accounts receivable to the Agency the first day after every checkwrite. If the provider has excess funds in their account a refund will be issued in the next checkwrite.
3.07.135	The Vendor shall enter all provider and Medicaid requested adjustment transactions into the MMIS within ten (10) days of notification.
3.07.136	The Vendor shall provide to the Agency a report listing lump-sum adjustments within one (1) day after every provider checkwrite.
3.07.137	The Vendor shall create facsimiles of electronic adjustments and image paper adjustment requests and make available on-line via provider ID, recipient ID or transaction number within one (1) day of receipt.
3.07.138	The Vendor shall process audit payments/credits within ten (10) days of notification.
3.07.139	The Vendor shall process Medicaid-established individual and gross lump sum adjustments to providers on the provider payroll following receipt of the request from Medicaid within ten (10) days of notification.
3.07.140	The Vendor shall ensure all provider 1099s and claims history reflect all voided checks; Vendor issued manual checks, audit adjustments and provider personal checks.
3.07.141	The Vendor shall provide the on-line real-time capability to update cash receipts.
3.07.142	The Vendor shall ensure that all financial reports generated during a HIPP financial cycle only reflect HIPP transactions.
3.07.143	The Vendor shall ensure that all financial reports generated during a Provider financial cycle only reflect Provider transactions.
3.07.144	The Vendor shall produce required monthly and quarterly reports to document that claims payments are made in accordance with the prompt pay provisions of the American Recovery and Reinvestment Act (ARRA) of 2009. Reports shall be delivered in accordance with the monthly and quarterly report delivery requirements.

3.08 Third Party Liability (TPL) Requirements

The Third Party Liability (TPL) function provides capabilities to manage the commercial health insurance coverage records and other third party resources of Medicaid recipients to ensure that Medicaid is the payor of last resort. This function works with a combination of cost avoidance (claim denial), cost recovery (post-payment billing), and case tracking (benefit recovery). In addition, the TPL function supports the Health Insurance Premium Payment (HIPP) process that

pays the health insurance premiums for selected recipients when it is cost-effective. The TPL function also supports Medicare claim recoupments (adjustments) from providers during monthly post payment processing. To the maximum extent possible, the AMMIS uses automated processes for cost avoidance. Cost recovery shall be utilized as a backup to the avoidance process or for mandated "pay-and-chase" claims.

The information maintained by the AMMIS TPL function includes recipient TPL resource data, insurance company data, benefit recovery case tracking data and TPL accounts receivable data. TPL coverage type rules and threshold information is used in the Post Pay Billing process to identify claims for recovery activities.

The primary objectives of the AMMIS TPL function are to:

- Identify third party resources available to Medicaid recipients.
- Avoid paying for claims with potential third party coverage.
- Recover funds from third parties when TPL resources are identified retroactively or for mandated "pay-and-chase" payments.
- Meet federal and State TPL reporting requirements.
- Pay the health insurance premiums for recipients when it is deemed cost-effective to do so.

The Third Party Liability subsystem consists of five major processes:

1. **TPL Policy** - maintain TPL policy information, through accepting adds, updates or deletes from various external entities.
2. **HIPP** - maintain and process HIPP information and payments.
3. **Post Pay Billing and Recoupment** - recover money on Medicaid paid claims where other entities are liable due to other insurance.
4. **Case Tracking** - recover money on Medicaid paid claims where other entities are liable.
5. **TPL Reports** - used in the maintenance of TPL information.

The following are the requirements identified by the Agency that must be met by the Vendor to support the successful operation of the Third Party Liability functions.

New #	Third Party Liability Requirements
3.08.001	The Vendor shall edit paid claims using Agency-defined criteria to identify potential trauma cases.

New #	Third Party Liability Requirements
3.08.002	The Vendor shall accumulate paid claims as applicable to threshold amounts, claim type and time period as designated by the Agency in order to generate Accident questionnaires from claims history data.
3.08.003	The Vendor shall produce reports, in accordance with Agency-specified criteria, within three (3) days of completing the month-end cycle to identify paid trauma claims and no active trauma case.
3.08.004	The Vendor shall generate and mail accident questionnaires weekly, to recipients as a result of trauma claim editing. The questionnaires shall be bar coded for tracking purposes.
3.08.005	The Vendor shall provide on-line real-time search and update capability to a recovery case tracking system for designated Agency and Contractor staff. The search capability shall allow staff to search by: Case number, Current ID, Recipient Last Name, Recipient First Name, Recipient SSN, Recipient DOB, and Case Type.
3.08.006	The Vendor shall maintain the capability for Agency staff to create recipient and case specific Trauma/Estate (T/E) cases on-line real-time.
3.08.007	The Vendor shall maintain the capability to load T/E cases to the system received from the TPL Contractor within twenty-four (24) hours of receiving a file from the Contractor.
3.08.008	The Vendor shall maintain the capability for Agency staff to request hard copy recipient profiles on-line real-time using date parameters or report request indicator on T/E cases.
3.08.009	The Vendor shall produce and deliver to Agency staff hard copy recipient-history profiles for T/E cases within twenty-four (24) hours of request.
3.08.010	The Vendor shall maintain/update on-line real-time T/E case files as directed by the Agency.
3.08.011	The Vendor shall maintain the capability for designated Agency staff to use the T/E case tracking letter panel to generate accident questionnaires and other case correspondence on-line real-time.
3.08.012	The Vendor shall generate and mail, on a daily basis, accident questionnaires (current TPL-9010-R format) requested through Agency input to the T/E case tracking panel.
3.08.013	The Vendor shall generate and distribute to Agency staff all letters, except accident questionnaires, requested as a result of Agency input to the T/E case tracking panel. Automatically system-insert Agency-specified data from the T/E case to the letter. The Vendor shall deliver these letters to Agency staff within twenty-four (24) hours of request.
3.08.014	The Vendor shall calculate amount due Medicaid for insertion in system-generated T/E letters, taking into consideration attorney fee percentages entered in the T/E case.
3.08.015	The Vendor shall support recovery efforts through the identification of claims that are potentially recovery-related (casualty, personal injury, estate recovery, liens, etc.) based on claim diagnoses, charges, procedures, accident forms, insurance information, dates of service and other claim data.
3.08.016	The Vendor shall accumulate on-line real-time paid claims as applicable to threshold amounts, claim type, and time period as assigned by the Agency.

New #	Third Party Liability Requirements
3.08.017	The Vendor shall provide the on-line real-time capability to allocate recoveries at the header level for a case.
3.08.018	The Vendor shall provide the on-line real-time capability for the Agency to initiate letters for case recovery for trauma, health insurance, recoupment, estate recovery, and HIPP. The Vendor and the Agency will generate these letters. The Vendor shall forward to the Agency letters that they have requested except those for health insurance within twenty-four (24) hours of generation. The Vendor shall mail health insurance letters within twenty-four (24) hours of generation.
3.08.019	The Vendor shall extract claims data, on-line real-time, that meets date specific selection criteria entered by Agency staff on the T/E case. The Vendor shall exclude claims, on-line real-time, previously extracted for the case and then populate remaining claims data to the T/E case to support trauma and estate recovery case activities.
3.08.020	The Vendor shall maintain the on-line real-time capability to post multiple recoveries to a T/E case.
3.08.021	The Vendor shall maintain the on-line real-time capability to adjust payments previously dispositioned to a casualty case or health insurance accounts receivable.
3.08.022	The Vendor shall maintain the on-line real-time capability to delete outstanding balances on a case.
3.08.023	The Vendor shall maintain the on-line real-time capability to identify, through DSS, T/E cases that closed with no recovery and those for which payment was received.
3.08.024	The Vendor shall maintain UI panels that allow the Agency or their contractor to enter on-line real-time selection criteria to identify paid claims for tracking and potential recovery of T/E cases.
3.08.025	The Vendor shall process daily Buy-In and Medicare entitlement data transmissions from the Agency's AMAES file. The Vendor shall process within 24 hours of receipt the Agency provided semi-monthly Medicare Enrollment Data Base (EDB) file. The Vendor shall use the EDB file and Buy-In dates to create Medicare entitlement dates in accordance with Agency-specified criteria and for use in Medicare editing.
3.08.026	The Vendor shall maintain TPL-related data from the adjudicated claims history files, to include but not be limited to: - Diagnosis codes indicating trauma; - TPL payment/denial indicators (TPL Input/Output Codes, NCPDP); and - Insurance company and policy identifiers, including policy and group numbers.
3.08.027	The Vendor shall maintain on-line real-time search and sort capabilities on TPL panels. The Vendor shall maintain current drop-down boxes on TPL UI panels.
3.08.028	The Vendor shall submit third party billings using HIPAA-compliant formats. If billings cannot be submitted using HIPAA format, the Vendor shall use national standard or Agency-approved formats that are accepted by the third party.
3.08.029	The Vendor shall comply with HIPAA privacy safeguards as they pertain to release of

New #	Third Party Liability Requirements
	recipient data.
3.08.030	DSS shall have pre-defined ("canned reports") that will serve as a tracking and reporting mechanism to inform the Agency TPL unit when follow-up actions are needed for post-payment billing and T/E case tracking.
3.08.031	DSS shall allow Agency staff to produce management ad hoc reports through DSS.
3.08.032	The Vendor shall maintain on-line real-time mnemonic look-up panels with hyperlinks to the Recipient Policy, Carrier and T/E files.
3.08.033	The Vendor shall maintain on-line real-time search, sort and update capability for recipient-specific records for all available TPL resources to include but not be limited to: - Carrier ID - Policyholder Name - Recipient relationship to the Policyholder (e.g., self, spouse, child) - Subscriber Number, i.e., Subscriber SSN - HIPP indicator - Policy Number - Group Number - Employer Code - Recipient Name - Coverage Code (e.g. major medical, cancer) - Coinsurance/co-payment amount - Annual policy deductible amount - Unique identifiers to specify the nature of policy (e.g. absent parent coverage) - Source of TPL information (e.g., DHR, SSA) - Identification of person or process making the update - Recipient Medicaid Number - Suspect Code (TPL policy verification indicator) - Letter Selection drop down box for Recipient Questionnaire - Letter selection drop down box for Insurance Verification Letter - Date of Birth - Chronological Notes - Recipient SSN - Plan Type (e.g. Managed Care or fee for service) - Coverage Begin Date - Coverage End Date - Date of original add to file - Date of last update
3.08.034	The Vendor shall maintain on-line real-time all TPL policies with unlimited number of coverages per recipient.
3.08.035	The Vendor shall maintain capability for on-line, real-time update (e.g., add, change, delete) of recipient policy information by designated Agency staff. The Vendor shall allow update capability of one or more fields in an existing span of data.
3.08.036	The Vendor shall maintain on-line real-time an audit trail report on updates processed, i.e., add/change/delete indicator, data changed and operator ID as applicable on change actions.

New #	Third Party Liability Requirements
3.08.037	The Vendor shall process on-line, real-time adds, changes, and deletions to the recipient policy database.
3.08.038	The Vendor shall maintain electronic file with audit history of file updates
3.08.039	The Vendor shall edit all recipient policy and Medicare file updates (on-line and electronic updates) for completeness (e.g., missing data) and validity (e.g., valid recipient ID, valid company code, valid format).
3.08.040	The Vendor shall edit additions and updates to the recipient policy file/database to prevent the addition of duplicate records. The Vendor's system shall notify/alert the user of duplicate records and provide for override on duplicate alerts for designated Agency staff.
3.08.041	The Vendor shall transmit TPL information, including multiple insurance details if applicable, to providers using the Electronic Verification System (EVS) and the Electronic Claims Management System (ECM).
3.08.042	The Vendor shall transmit TPL information to third parties to the extent required for billing, identification and verification of coverage using HIPAA electronic transactions or other formats and acceptable by the third party. The Vendor shall transmit to third parties on a schedule approved by the Agency.
3.08.043	The Vendor shall maintain, at a minimum, the following carrier data: - Carrier ID ten (10) digit identifier that is system assigned - Carrier Name - Carrier Address (Claims submission address) - Carrier Telephone Number - Carrier Correspondence Address city, state, zip+4 - Carrier contact person and telephone number - Carrier Type Indicator (e.g. health, casualty, HMO, attorney, sponsor) - Billing Media Indicator (e.g. format for claims submission) - Date record added to Carrier File/database - Last manual update date - Last automated update date - Update Source ID - State Billing ID (assigned by third party payer)
3.08.044	The Vendor shall maintain on-line real-time search capability directly to the Carrier File by entering either of the following: carrier number, Full or partial carrier name, or Carrier zip code
3.08.045	The Vendor shall maintain on-line, real-time update capability of Carrier File by designated Agency and Contractor staff to add, change, or cancel records, including edits on cancel function. The Vendor shall ensure any carrier with active policies is not deleted, cancelled or inactivated.
3.08.046	The Vendor shall maintain the on-line real-time capability to delete and override alerts/edits of the Carrier File for designated personnel only.

New #	Third Party Liability Requirements
3.08.047	The Vendor shall allow users to select, on-line real-time, a specific carrier from a listing of carriers that meet the user's search criteria and hyperlink to the detail screen for that carrier.
3.08.048	The Vendor shall generate and mail letters to employers requesting health plan data within one (1) day of request.
3.08.049	The Vendor shall maintain on-line real-time a user-defined, table-driven TPL matrix (Other Insurance (OI) Plan Rules) based on comparison of claim data to the Recipient Policy File (RPF) data for cost-avoidance and post payment recovery editing.
3.08.050	The Vendor system shall identify and exclude from cost avoidance certain TPL-covered claims that meet cost avoidance exception criteria using procedure, diagnosis, drug or revenue code; provider type; and Absent Parent indicator and Plan type from the RPF. Claims meeting the cost avoidance exemption criteria will be identified and extracted during the TPL month-end processing for post-payment billing or recoupment.
3.08.051	The Vendor shall maintain on-line real-time tables of procedure codes that are exempted from TPL and Medicare editing. The Vendor shall process all updates within three (3) days of request.
3.08.052	The Vendor shall produce and provide to the Agency Cost Avoidance Savings Reports utilizing logic that excludes each claim that meets the following duplicate criteria, i.e., same data in a new-month claim as in a previous month for State ID, provider number, first date of service, last date of service. The Vendor shall provide the report on the 1st day of each month for the previous month's savings data.
3.08.053	The Vendor shall maintain and operate the TPL component of the MMIS, including future Agency-directed improvements as they are implemented.
3.08.054	The Vendor shall maintain and utilize TPL coverage information, including Medicare coverage, for claims processing.
3.08.055	The Vendor shall maintain for designated Agency and TPL Contractor staff on-line access and real-time update to TPL-related files, including the Carrier (i.e., insurance companies, employers, attorneys, and other payers); Recipient Policy; Employer; Absent Parent; CROCS; Medicare; Trauma/Estate Recovery; Accounts Receivable; and Letter Tracking Files. The Vendor shall process daily on-line and batch adds/updates of policy information so that it is applied to claims editing.
3.08.056	The Vendor shall research, resolve and respond to TPL inquiries received from providers regarding claims processing within one (1) day of receipt. The Vendor shall as needed, refer inquiries to the Agency for resolution and policy interpretation within two (2) days of receipt.
3.08.057	The Vendor shall perform data matches on an Agency-defined schedule with other entities to identify/verify third party resources and produce reports within two (2) days of receiving output from the data exchange. The Vendor shall update the RPF with data match information, as directed by the Agency, within two (2) days of Agency notification.

New #	Third Party Liability Requirements
3.08.058	The Vendor shall provide data extracts for the Agency and other entities, at Agency direction, to conduct data matches for the purpose of identifying and verifying TPL resources according to an Agency approved schedule for each entity.
3.08.059	The Vendor shall maintain automated interfacing capabilities (including HIPAA 270, 271, 835, 837 and other Coordination of Benefits (COB) and TPL-related HIPAA electronic transactions) with external entities to identify and verify third party resources, submit claims to third party payers, and receive and process electronic and paper third party payment/denial information. External entities are currently BC/BS of Alabama, Tricare, Retirement Systems of Alabama (RSA), Dept. of Human Resources (DHR), United American Insurance Co. (UAIC), Medco, DEERS, and Third Party Contractor. HIPAA electronic standards shall be used unless other formats are acceptable by the other payer and are approved by the Agency. The Vendor shall support concurrently all HIPAA ASC X12 transactions in both 4010 and 5010 formats.
3.08.060	The Vendor shall maintain paper interfacing capabilities with external entities to identify/verify third party resources, submit claims to third party payers, and receive and process payments/denials. External entities include but are not limited to: all health and liability insurance plans, employers, providers, recipients and other entities that may provide third party information or pay claims. Paper claims shall be in the national standard format or other format accepted by the external entity and approved by the Agency.
3.08.061	The Vendor shall maintain access to all TPL data through DSS. This shall include all Policy Segment, Trauma/Estate Recovery Case, Medicare, Carrier, Absent Parent, Medicare Advantage, and Accounts Receivable data.
3.08.062	The Vendor shall submit to the Agency all TPL reports created by the MMIS in a manner and format approved by the Agency as listed in Alabama MMIS Reports Listing located in the Procurement Library. The Vendor shall ensure all reports meet federal and Agency Third-Party Liability reporting requirements.
3.08.063	The Vendor's system shall capture and report all TPL collections, post-payment recoveries, and cost-avoidance data necessary to complete the third party section of the CMS-64, Quarterly Report of Expenditures and to monitor TPL collections and cost avoidance. The current reports include: TPL-0016-M Cost Avoidance TPL-0027-M Casualty Collections, TPL-0033-M Cost Avoidance Summary - CMS Calculations TPL-0034-M Cost Recovery Summary - CMS Calculations TPL-0038-M HIPP Monthly Payment Detail TPL-0101-M TPL Monthly Recoveries The Vendor shall provide reports on the 1st day of each month for the previous month's savings data.
3.08.064	The Vendor shall maintain the on-line real-time capability to separately identify TPL post-payment billings that are closed based on each Agency code, (e.g., no response from carrier, not cost effective to pursue, deductible not met).

New #	Third Party Liability Requirements
3.08.065	The Vendor shall provide TPL related on-line systems training for at least twenty-four (24) Agency and Contractor staff monthly and as requested by the Agency.
3.08.066	The Vendor shall provide an on-line user manual to instruct Agency staff in accessing TPL information. The Vendor shall maintain the on-line user manual to reflect current system functions. The Vendor shall provide current, complete and comprehensive TPL documentation for Agency-specific processes. The Vendor shall make requested modifications within two (2) days of request.
3.08.067	The Vendor shall make available to providers hard copy listings and/or on-line access to the TPL carrier file data. Such data shall include but not be limited to: carrier codes, names and claim filing addresses. The Vendor shall mail carrier information within one (1) day of request. Carrier information shall be available as part of the Provider Billing Manual.
3.08.068	The Vendor shall produce reports that identify the following by current month and fiscal year-to-date. The Vendor shall ensure the reports list drug claims separately to include but not be limited to: - Total number of adjudicated claims with TPL payments - Total TPL payments - Total Savings - Total “Billed Amount to Medicaid” - Total “Medicaid Allowed Amount” - Total “Medicaid Paid Amount” - Current month’s Grand Total that combines each of these figures for drug and non-drug claims - Fiscal Year-to-Date Grand Total that combines each of these figures for drug and non-drug claims. The Vendor shall provide reports on the 1st day of each month.
3.08.069	The Vendor shall provide and maintain an on-line real-time case tracking system for TPL cases including health insurance cases, HIPP cases, estate recovery cases, trauma cases and recipient recoupment cases.
3.08.070	The Vendor shall meet all minimum insurance processing requirements defined in Section 3910 of the State Medicaid Manual.
3.08.071	The Vendor shall maintain on-line real-time TPL information for claims processing.
3.08.072	The Vendor shall display on COLD all TPL reports created by the MMIS as identified in the Alabama MMIS Reports Listing located in the Procurement Library.
3.08.073	The Vendor shall update TPL forms and letters as changes become necessary within the identified timeframe given in the request.
3.08.074	The Vendor shall produce hard copy Agency-designated reports as identified in the Alabama MMIS Reports Listing located in the Procurement Library.
3.08.075	The Vendor shall use the TPL Other Insurance (O/I) Plan Rules, Recipient Policy File, TPL edits on pricing file, claim data and other Agency-defined TPL edit criteria to process and identify paid claims for post-payment billing/recoupment.

New #	Third Party Liability Requirements
3.08.076	The Vendor shall maintain on-line real-time diagnosis information to identify prenatal care, well child care, cancer and accidents to support post-payment recovery for applicable services.
3.08.077	The Vendor shall produce monthly reports on the TPL recoupments in the following areas: - Medicare - Maternity care - E diagnosis - Circumcision - Hospital encounter of maternity care stay The reports shall be available the day after monthly processing for these areas is complete.
3.08.078	The Vendor shall ensure Agency-defined thresholds are met or exceeded for post-payment billing.
3.08.079	The Vendor shall identify and extract paid claims for TPL post-payment billing that meet federal and Agency-defined cost avoidance exception criteria. These services include but are not limited to: pay and chase requirements: preventive pediatric services, prenatal services outside of maternity waiver, claims for which there is a TPL policy that is court ordered and other services identified for post-payment recovery through the TPL OI Plan Rules and other TPL edits.
3.08.080	The Vendor shall for claims identified for post-payment billing, generate and transmit electronic or paper post-payment bills to insurance companies in accordance with insurance plan requirements . Claims submitted electronically shall be submitted in HIPAA-compliant formats, including Coordination of Benefits (COB) format, unless otherwise directed by the Agency. The Vendor shall use existing paper formats where paper is required. The Vendor shall automatically generate and mail the necessary documentation for submission of each bill to an insurance company. The documentation shall include but not be limited to: - Initial cover letter - Claim facsimiles - Billing summary - Follow-up letters and reports (as applicable)
3.08.081	The Vendor shall ensure for paper billing, print insurance information (i.e., company and policy information) directly on Agency-approved post-payment billing claim forms, including CMS-1500, UB-92, pharmacy, dental claim forms or other mandated forms. The forms must be acceptable by the receiving entity.
3.08.082	The Vendor shall track responses on-line real-time for company billings through reason/status information on the accounts receivable as well as the capability to enter chronological notes.
3.08.083	The Vendor shall automatically re-bill insurance companies if a response (payment or denial) is not received within sixty (60) days from the initial billing.
3.08.084	The Vendor shall automatically generate a second re-billing notice to insurance companies if a response (payment or denial) is not received within ninety (90) days from the initial billing.

New #	Third Party Liability Requirements
3.08.085	The Vendor shall identify rejected post-payment recovery claims on electronic remittances once the CCN has been added by the TPL unit and a request has been sent via email to the Vendor. The Vendor shall generate reports and notify the TPL unit that they are available for review within one (1) day of Agency request. Current reports that are generated for this requirement are: TPL-A075-R TPL Electronic Remittance Summary TPL-A076-R TPL Credit Balance TPL-A077-R TPL Payments Received Not Posted TPL-A078-R TPL Denials Posted - Needs Research TPL-A079-R TPL Denials With Invalid AR Number - Not Posted TPL-A080-R TPL AR Payments Posted TPL-A081-R TPL Denials Posted
3.08.086	The Vendor shall update accounts receivable and claim history records from electronic remittances and report information to the Agency in an Agency approved format within one (1) day of request. Reports shall contain the data elements needed by the Agency to approve electronic updates/posting by the Vendor and to enable the Agency to perform manual postings/updates. Current reports that are generated for this requirement are: TPL-A075-R TPL Electronic Remittance Summary TPL-A076-R TPL Credit Balance TPL-A077-R TPL Payments Received Not Posted TPL-A078-R TPL Denials Posted - Needs Research TPL-A079-R TPL Denials With Invalid AR Number - Not Posted TPL-A080-R TPL AR Payments Posted TPL-A081-R TPL Denials Posted
3.08.087	The Vendor shall maintain a recipient and claim specific on-line real-time accounts receivable tracking file for automated post-payment recovery (i.e., pay-and-chase claims, rebills and retroactive insurance) billing.
3.08.088	The Vendor's system shall print the “total billed charge” and “total paid by Medicaid” on each post-payment claim.
3.08.089	The Vendor shall print procedure and diagnosis code descriptions directly on the claim facsimile.
3.08.090	The Vendor's system shall print the applicable provider billing ID, Tax ID and State Provider number on claims sent to insurance companies requiring unique billing numbers.
3.08.091	The Vendor's system shall print the provider name and address (physical location) information directly on claim facsimiles sent to an insurance company.
3.08.092	The Vendor shall ensure bills are generated to all insurance companies providing coverage to a recipient where the service provided is covered by the recipient's policy(ies).

New #	Third Party Liability Requirements
3.08.093	The Vendor shall maintain the capability to generate claims electronically and on paper to Blue Cross – Blue Shield, Tricare, Medco and other payers. The Vendor shall submit claims in the HIPAA-compliant or other format required by the other payer.
3.08.094	The Vendor shall maintain the capability to bill multiple companies in cases where a recipient is covered by multiple insurance companies/policies.
3.08.095	The Vendor shall process the Recipient Policy File and Carrier File updates in real time or in special batches within two (2) days of the Agency request.
3.08.096	The Vendor shall maintain an on-line real-time claims post-payment billing file to support TPL activities.
3.08.097	The Vendor shall ensure that claims added to the billing file can be adjusted and the recipient history file updated on-line real-time.
3.08.098	The Vendor shall maintain electronic media interchange (835 files) for post-payment recovery (remittance advices, etc.) for sixty (60) months.
3.08.099	The Vendor shall maintain on-line real-time update capability to authorized Agency staff to credit paid claims history and to post TPL or Medicare payments or denials, with no limit on the number of recoveries per case.
3.08.100	The Vendor shall process and track partial and full third party payments to recipient-specific post-payment billings. Payments and denials other than electronic will be forwarded to the Agency within two (2) days of receipt for Agency processing. Electronic remittances shall be posted by Vendor within one (1) day of Agency approval to process and in accordance with Agency criteria.
3.08.101	The Vendor shall create on-line real-time trauma case files, etc., which can be updated by Agency staff and be used by the Vendor and Agency staff to send out questionnaires and other case correspondence.
3.08.102	The Vendor shall provide on-line real-time the ability to initiate letters through the trauma case file including requests to any carrier and to other parties involved in the accident and/or to attorneys. The Vendor and the Agency will generate these letters. The Vendor shall forward to the Agency letters that they have requested within twenty-four (24) hours of generation.
3.08.103	The Vendor shall produce electronic and paper claims (claim facsimiles) to bill companies, including Tricare, for postpayment recoveries and for claims paid when retroactive TPL has been identified for all claim types in formats required for claims. The Vendor shall produce electronic billings when acceptable by the other payer and in the format approved by the other payer. Paper claims shall be submitted for payers who do not accept electronic submission. Paper claims shall be submitted for all claim types in formats required by other payer for processing. The Vendor shall mail with appropriate cover letters or transmit within two (2) days of month-end approval.
3.08.104	The Vendor shall provide the on-line real-time capability for the Agency to identify post payment recoveries or claims adjustments by carrier and claim type.
3.08.105	The Vendor shall provide designated Agency staff on-line real-time add and update capability

New #	Third Party Liability Requirements
	to the Integrated Accounts Receivable.
3.08.106	The Vendor shall provide Agency staff with on-line real-time access to claims billed. The Vendor shall provide capability through COLD for Agency staff to obtain paper copies of claims in national standard format for follow-up. The Vendor shall provide the Agency with the on-line real-time capability to identify specific claims for rebilling through paper or electronic submission.
3.08.107	The Vendor shall ensure the generation of documentation for company billings, including cover letters, claim facsimiles, billing summaries, and follow-up letters (as applicable). The Vendor shall maintain this documentation as part of the Accounts Receivable System so that it can be easily retrieved in COLD.
3.08.108	The Vendor shall perform postpayment recovery on claims paid to providers for which a liable TPL is determined subsequent to Medicaid payment. This recovery process shall be accomplished through the production of monthly invoices for all claim types (including drugs) in a timeframe and format determined by the Agency. Follow-up and appropriate timeframes shall be in compliance with Federal regulations and Alabama Medicaid TPL Month-End Process Requirements located in the Procurement Library.
3.08.109	The Vendor shall perform postpayment recovery on claims retroactively identified as covered by Medicare. The recovery shall be through recoupment of claims from providers as defined by the Agency's Medicare recoupment matrix.
3.08.110	The Vendor shall provide to the Agency monthly reports on the status of all postpayment activities and billings by company, type of recovery, including aged accounts receivable for postpayment recoveries, and other criteria as designated by the Agency. The reports shall be available within two (2) days of the Agency approving the pre-production process reports.
3.08.111	The Vendor shall report TPL billing activity to the Agency by type of TPL, dollars recovered versus potential dollar recovery, insurance company, diagnosis, and other appropriate indicators of program activity in accordance with the Alabama MMIS Reports Listing located in the Procurement Library.
3.08.112	The Vendor shall maintain an accurate and up-to-date section in the Provider Billing Manuals which describes the procedures for providers to follow in cases of potential TPL.
3.08.113	The Vendor shall for each policy added or updated on the RPF during the month's financial cycle, automatically perform retroactive review of previously paid claims. The Vendor shall identify and extract those claims determined through TPL editing to be covered. The Vendor shall exclude claims with a TPL Input Code = R and/or a TPL amount > $0.00. The Vendor shall generate TPL billings or recoup in accordance with Agency-defined criteria.
3.08.114	The Vendor shall maintain an automated threshold and time-based tracking mechanism to use in generating accident questionnaires.
3.08.115	The Vendor shall track and report on the status of questionnaires. The Vendor shall use an on-line real-time letter tracking file to track accident questionnaires.

New #	Third Party Liability Requirements
3.08.116	The Vendor shall based on specific trauma diagnoses and the time period specified by the Agency automatically accumulate potential trauma claims and generate accident questionnaires to the recipient when the threshold has been met or exceeded.
3.08.117	The Vendor shall maintain an on-line real-time T/E File that is recipient specific and accepts user-specified search criteria (such as recipient ID, date ranges, etc.) to identify paid claims for tracking and potential recovery.
3.08.118	The Vendor shall maintain an on-line panel for T/E letter selection, case tracking and other payer data associated with the summary case data. Data from the summary case record shall automatically populate the corresponding case tracking data. The Vendor shall maintain on-line real-time summary case data along with claim information. The summary case data shall include but not be limited to the following: - Case number - Case Type - Recipient name - Recipient number - Policyholder/Sponsor name and address - Accident Date/Date of Death - Total case amount (original) and date - Total case amount (revised) and date - Lien amount - Amended lien amount - Period Covered (from and through) - Recovered Amount (the current disposition amount) - Total Received amount (sum of all disposition to the case) - Settlement Amount (includes the amounts paid to Medicaid, the Recipient, recipient's attorney, etc). - Settlement Date (the date the recipient settled their case) - Recipient Settlement Amount (the amount the recipient received from the settlement) - Deleted Amount (Medicaid write-off amount) - Request Report indicator - Case Status Code - Case Add date - Source - Carrier code (identifies third party making payment) - Carrier Case Type - CCN (Identifies the check from which the disposition is made) - Release Date (Close Date) - Tickler Date - Attorney Percentage - Chronological Notes
3.08.119	The Vendor shall automatically create on-line real-time T/E case records from input by Agency staff. The case will include the following: all the claims selected by the user, accounts receivable information, billing information, letter selection and tracking capability, case type and other case specific data.

New #	Third Party Liability Requirements
3.08.120	The Vendor shall automatically display on-line real-time a T/E File listing of all claims data that meet user-entered criteria. The Vendor shall provide a hardcopy listing of claims data within twenty-four (24) hours of entry of the request.
3.08.121	The Vendor shall provide the capability for the Agency or TPL contractor to add/update case tracking data pertaining to Attorney, Tortfeasor and Insurance Agent.
3.08.122	The Vendor shall maintain on-line, real-time update capability for users to manually select and/or deselect claims from the claims listing for inclusion in a case (e.g., zero-paid Medicaid claims, claim diagnosis indicates service paid by Medicaid was not related to accident in question).
3.08.123	The Vendor shall maintain the on-line real-time capability to re-select claims that were deselected from the case.
3.08.124	The Vendor shall maintain and display on-line real-time data for each claim associated with a case. The data shall include but not be limited to: - ICN - Provider name - Provider number - Recipient ID - Medicaid Payment amount - Claim Status - Amount Billed to Medicaid - Dates of service (from and to) - Claim Type - Medicaid Paid Date
3.08.125	The Vendor shall automatically update in on-line real time the summary case record when claims are added or deleted from a case, including update of the Original or Revised Case Amount based upon the T/E claims selected by the user.
3.08.126	The Vendor shall produce weekly reports which identify accident claims of recipients that meet the threshold and do not have a T/E case established. The report criteria shall be approved by the Agency and the reports shall be provided to the Agency the first day of each week.
3.08.127	The Vendor shall identify on-line real-time the type of recovery (e.g., worker's compensation, tort, estate recovery) on the case tracking file and the accounts receivable file.
3.08.128	The Vendor shall maintain an on-line real-time cash receipts file that is fully integrated with the case tracking file to allow company checks and settlements to be applied to the entire case.
3.08.129	The Vendor shall maintain the capability to retain claims history on-line real-time indefinitely for recipients with open recovery cases.
3.08.130	The Vendor shall produce monthly listings, reports and/or electronic files of all payments received for T/E cases and shall be provided to the Agency on an approved schedule.

New #	Third Party Liability Requirements
3.08.131	The Vendor shall maintain an on-line real-time history of all actions and action dates associated with the T/E case.
3.08.132	The Vendor shall maintain the capability to maintain and display on-line real-time multiple names and addresses of the parties associated with a case (e.g. the attorney, the insurance company).
3.08.133	The Vendor shall maintain the capability to maintain settlement data on-line, including but not be limited to settlement date and total settlement amount.
3.08.134	The Vendor shall create Medicaid eligibility extracts for Medicare according to the CMS schedule. The file shall be transmitted or uploaded to Medicare per their specifications. The extracts shall include Medicaid recipients with current eligibility or recipients whose eligibility has been terminated within the past twelve (12) months and recipients with current Medicare coverage. The extract shall include all recipients with Medicare Part A, Part B and Part B-DMERC. The data in the extract shall contain the data required by Medicare and be in the format defined by Medicare.
3.08.135	The Vendor shall on a monthly basis generate automated form letters to Medicaid eligibles who have an open-ended coverage record on the RPF, when "Last Updated Date" is twelve (12) months ago, to inquire if recipient's insurance is still current and to request recipient to advise Agency of other insurance. The letters shall be mailed within two (2) days of processing.
3.08.136	The Vendor shall provide on-line real-time search and ad hoc reporting capability with the recipient eligibility file.
3.08.137	The Vendor shall maintain on-line real-time search and sort capability to the Medicare data for Agency staff.
3.08.138	The Vendor shall maintain on-line add/update capability to selected data fields on the Medicare Coverage Panels by a limited number of designated Agency staff.
3.08.139	DSS shall maintain the capability to produce a report identifying, by carrier code, outstanding TPL billings.
3.08.140	The Vendor shall provide, for Agency approval, the pre-production report generated from the first month-end process identifying rebilled claims within two (2) days after the end of each month. The Vendor shall not create accounts receivable records prior to Agency approval of the pre-production information.
3.08.141	The Vendor shall update the TPL cost-avoidance matrix (OI Plan Rules) and Medicare and TPL non-covered procedure code groupings within three (3) days of the request by the Agency unless otherwise approved by the Agency.
3.08.142	The Vendor shall submit a file to DEERS for data match (270 transactions) so that the file is received by DEERS within the timeframe designated by CMS for Alabama.
3.08.143	The Vendor shall receive the DEERS return file (271 transactions) and add/update policy records according to criteria defined by the Agency.

New #	Third Party Liability Requirements
3.08.144	The Vendor shall conduct an annual data match with Retirement Systems of Alabama (RSA) in the month following the end of RSA's open enrollment period, unless otherwise designated by the Agency.
3.08.145	The Vendor shall conduct a monthly data match with the Department of Human Resources' Child Support File on a schedule approved by the Agency. The Vendor shall update the absent parent data stored on the MMIS and send a copy of the DHR return file to the designated TPL contractor.
3.08.146	The Vendor shall post third party billings to the TPL accounts receivable file within two (2) days of Agency approval of the pre-production billing report.
3.08.147	The Vendor shall ensure on-line questionnaires and correspondence requests are printed at the workstation of the requestor.
3.08.148	The Vendor shall generate paper and electronic post-payment billings within two (2) days of Agency approval of the pre-production billing reports. The Vendor shall systematically add accounts receivable records for the billing cycles.
3.08.149	The Vendor shall mail/transmit post-payment billings within three (3) days of production of paper and electronic post-payment billings.
3.08.150	The Vendor shall update within two (2) days the TPL accounts receivable file to indicate the date when the first or second re-bill has occurred, once the Agency has approved the pre-production rebill report.
3.08.151	The Vendor shall generate and mail/transmit re-bill claims within two (2) days of Agency approval of the re-bill report once the TPL accounts receivable file has been updated. The Vendor shall use the same Accounts Receivable number based upon Agency defined criteria.
3.08.152	The Vendor shall maintain an automated Recipient Medicare Coverage file and process daily AMAES transmissions, manual updates of Medicare coverage dates received from the Agency, and the Agency provided semi-monthly Medicare EDB file.
3.08.153	The Vendor shall generate HIPAA 270 eligibility verification transactions and systematically process the 271 eligibility response file.
3.08.154	The Vendor shall print and mail, within one (1) day, paper TPL verification forms when a non-verified policy record is added to the policy file.
3.08.155	The Vendor shall update the Recipient Policy File from claims information and HIPAA 271 eligibility transaction responses according to Agency defined criteria. The Vendor shall provide the Agency with Recipient Policy File pre-production (BC/BS) or actual production (DEERS) reports within two (2) days of file update. The Vendor shall provide the Agency with Recipient Policy File production (BC/BS) reports within two (2) days of the Agency approval of the pre-production reports.

New #	Third Party Liability Requirements
3.08.156	The Vendor shall provide recipient TPL information to providers through automated voice response system (AVRS) and electronic verification system (EVS). The Vendor shall provide recipient TPL information to providers through remittances for claims denied for Medicare and other insurance. The Recipient Policy File information shall include but not be limited to: the insurance company, policy number, group number, plan code, and dates and types of coverage. The Medicare information shall include the Medicare Claim Number.
3.08.157	The Vendor shall generate and mail letters daily to employers and insurance companies to verify TPL coverage based on Agency input to the Recipient Policy File. The Letters shall be bar coded for tracking purposes.
3.08.158	The Vendor shall generate and mail letters daily to recipients when requested on-line through the Recipient Policy File. These letters shall request insurance information and alert recipients of requirements to use plan providers, pre-certifications, etc. The letters shall be bar coded for tracking purposes
3.08.159	The Vendor shall generate on a weekly basis TPL insurance questionnaires and mail them to recipients when a potential third party resource is identified from current month's claims and there is no Recipient Policy File segment showing coverage. The letters shall mailed within two (2) days and be bar coded for tracking purposes.
3.08.160	The Vendor shall generate on a weekly basis using the TPL Carrier Code as specified by the Agency, TPL insurance questionnaires and mail them to insurers when claims show insurance and no insurance is shown on the TPL file. The letters shall mailed within two (2) days and be bar coded for tracking purposes.
3.08.161	The Vendor shall identify and report monthly to the Agency information detected during processing activities (e.g., claims processing, adjustment processing, data exchange, month-end processing) that indicates changes in third party coverage. The reports shall be available within two (2) days of processing.
3.08.162	The Vendor shall identify and report claims, based on exception processing, that indicate potential third party coverage not reflected on the RPF. The Vendor shall provide the report within two (2) days of the processing.
3.08.163	The Vendor shall edit all on-line and electronic Carrier updates for completeness (e.g., missing data) and validity (e.g., valid carrier name, carrier ID, carrier address, valid format).
3.08.164	The Vendor shall automatically assign unduplicated carrier identification numbers and resolve update errors.
3.08.165	The Vendor shall maintain on-line access and real-time updates to Employer data for designated Agency and Contractor staff.
3.08.166	The Vendor shall edit all on-line and electronic Employer updates for completeness (e.g., missing data) and validity (e.g., employer name, employer ID, employer address, valid format).
3.08.167	The Vendor shall maintain edits on the Pricing File, TPL Matrix, and hard-coded edits, where required, to identify non-covered Medicare and TPL services for processing exclusions to relevant Medicare and TPL edits.

New #	Third Party Liability Requirements
3.08.168	The Vendor shall edit for cost-avoidance using all of a recipient's policies on the Recipient Policy File when there are multiple policies. The Vendor shall alert providers of specific policies showing coverage for a billed service.
3.08.169	The Vendor shall maintain the capability for Agency staff to create on-line accounts receivable entries for individuals not on the Medicaid eligibility file.
3.08.170	The Vendor shall maintain the capability for Agency staff to create on-line real-time accounts receivable entries for unsolicited funds.
3.08.171	The Vendor shall provide the capability for Agency staff to manually identify to the Vendor specific claims for correction and rebilling.
3.08.172	The Vendor shall provide and maintain on-line real-time access to third party electronic remittance data in accordance with Agency requirements. The Vendor shall provide the capability to associate such data with the corresponding accounts receivable record and check control number (CCN).
3.08.173	The Vendor shall provide TPL checks received from providers and/or other third party payers to the Agency for deposit within one (1) day of receipt.
3.08.174	The Vendor shall generate and store for on-line access reports that depict the total TPL amounts billed and recovered by carrier and by recipient. The Vendor shall maintain the capability in DSS to obtain amount recovered by carrier and/or recipient on the TPL A/R file.
3.08.175	The Vendor shall following each financial cycle maintain the TPL data in DSS to generate adhoc queries and reports that identify TPL information. Reports shall include but not be limited to: - TPL denial and TPL editing indicates the claim is covered. - TPL payment that is below an Agency-established percentage of the billed amount.
3.08.176	The Vendor shall maintain the capability to post an unlimited number of checks to each accounts receivable record. This shall include both the health AR and T/E Case recovery AR record.
3.08.177	The Vendor shall maintain the capability to post TPL recoveries to recipient-specific accounts receivable entries.
3.08.178	The Vendor shall maintain the capability for Agency staff to create recipient specific on-line accounts receivable entries for manually billed claims.
3.08.179	The Vendor shall support the payment of HIPP premiums and cost sharing for recipients enrolled in employer group health plans and other health insurance as required by Section 4402 of the Omnibus Budget Reconciliation Act of 1990.
3.08.180	The Vendor shall provide extract files and transmit the data to an external entity on an Agency approved schedule. The data shall include but not be limited to: claims, recipient, TPL policy, TPL carrier, TPL Case Tracking, TPL Accounts Receivable.

New #	Third Party Liability Requirements
3.08.181	The Vendor shall maintain access to all TPL data through DSS. This shall include but not be limited to all Policy Segment, Trauma/Estate Recovery Case, Medicare, Carrier, Absent Parent, Medicare Advantage, and Accounts Receivable data. The Vendor shall maintain through DSS TPL-related claim data, including third party identifying information, COB data, claim override codes, and NCPDP other coverage payment and denial codes.

3.09 Drug Utilization Review (DUR) Requirements

The Drug Utilization Review component of the AMMIS is comprised of Prospective Drug Utilization Review (Pro-DUR). Pro-DUR is an on-line, real-time program, which alerts pharmacists to potential drug therapy concerns. The Pro-DUR function of the AMMIS gives providers an automated, integrated system which uses direct data transmission using ECM. Alerts are given to pharmacists in the areas of early refill, therapeutic duplication, drug/drug interaction, high dose alerts. Additional alerts are available but not currently active. The goal of the Pro-DUR functionality is to improve the quality of care given to recipients and to conserve program funds by screening drugs for potential drug therapy problems before the prescription is delivered to the patient. Pro-DUR also provides the capability to evaluate any alerts generated as a result of clinical or program compliance issues associated with a recipient's prescription. Pro-DUR can prevent the dispensing of inappropriate drugs through direct intervention. Pro-DUR allows the provider to assess the current (to be dispensed) prescription against both the claims history of the recipient and explicit, predetermined standards. DUR alert messages are returned to the pharmacist for the potential conflicts discovered during this review. It provides a methodology to monitor recipients who receive multiple drug prescriptions and indicate possible drug interaction conflicts, to monitor the pharmacists and providers who are dispensing and ordering drugs, and to monitor recipient’s patterns of utilization.

Since November 2000, the Agency has contracted with an external contractor for pharmacy administrative services to include Retrospective DUR (Retro-DUR). The Agency is responsible for the administration of the program, provides claims history to perform Retrospective DUR functions and is responsible for policy decisions and quality oversight. The Agency monitors and assesses the program utilizing current Agency staff.

The AMMIS and the Vendor must conform to the policies, standards and requirements set forth by the federally mandated Alabama Drug Utilization Review (DUR) Board and Alabama Medicaid Agency, which are responsible for setting policies regarding both Pro-DUR and Retro-DUR activities for the State of Alabama. The DUR Board serves in an advisory capacity to the Agency. The Agency remains the final authority on all policies, standards and requirements for drug utilization review in compliance with federal regulations.

The following are the requirements identified by the Agency that must be met by the Vendor to support the successful operation of the Drug Utilization Review related functions.

New #	Drug Utilization Review Requirements

New #	Drug Utilization Review Requirements
3.09.001	The Vendor shall maintain the capability to establish drug-disease history profiles. Profiles will be defined by the Agency.
3.09.002	The Vendor shall provide assistance to both providers and Agency staff with Pro-DUR training, as specified by the Agency. Training sessions shall be scheduled and conducted to teach Agency staff, State-designated organizations and active providers about the DUR program. This may be accomplished through any Agency approved means including provider workshops at State approved locations, the provider manual and provider newsletters. Active Providers may request training when necessary.
3.09.003	The Vendor shall implement additional Pro-DUR modules within five (5) days of Agency request. Examples include duration of therapy, drug to pregnancy contra-indication, drug allergy, age precautions and low dose. These modules shall be supported by commercially available database and drug information.
3.09.004	The Vendor shall provide a Help Desk to assist providers with technical problems associated with the use of Pro-DUR alerts. The Help Desk shall assist providers and network vendors with ECM access and answer claims processing questions concerning prospective DUR edits, state Maximum Allowable Cost (MAC), prior authorization and the Preferred Drug Program.
3.09.005	The Vendor shall provide Pro-DUR criteria or criteria enhancements information and data, as required, to the Alabama DUR Board or to Alabama Medicaid, or other designated agent within five (5) days of request.
3.09.006	The Vendor shall produce all Agency approved drug utilization reports currently produced and listed in the Alabama MMIS Reports Listing located in the Procurement Library.
3.09.007	The Vendor shall interface with the Retro-DUR Contractor to provide extract files which provide data from areas such as but not limited to, provider, reference, claims, recipient, and financial. Extract files shall be provided according to the Agency-approved schedule which specifies a weekly or bi-weekly basis.
3.09.008	The Vendor shall provide Pro-DUR updates to the Agency within five (5) days after updates are received from the external drug data warehouse contractor. The Vendor shall ensure that all alert statuses can be set to a default value as directed by the Agency. For example a GCN sequence number listed within the overuse precaution edit is set as active while other alert statuses are inactive. Currently updates are received on a monthly basis.
3.09.009	The Vendor shall provide and maintain on-line real-time access and search capabilities to claims history, recipient data, provider data, reference data, submitted claim information and prescription data from providers for Pro-DUR.
3.09.010	The Vendor shall perform, using the hardware and software capabilities of the Point of Service/Electronic Claims Submissions system, prospective drug utilization review to identify problems with inappropriate drug use or dispensing at the time of dispensing.
3.09.011	All communications and data exchange with providers must use NCPDP standards where appropriate.
3.09.012	The Vendor shall provide access on line real-time to MMIS files, including current information and historical information (e.g., claims history) for assessing potential problems.
3.09.013	The Vendor shall provide on line real-time capability to control edits/claim dispositioning at the GCN Sequence level of detail and /or Therapeutic Class (TC) level in accordance with Agency specifications.

New #	Drug Utilization Review Requirements
3.09.014	The Vendor shall identify and report to the provider (on-line, real-time) potential utilization and dispensing problems resulting from the following edits: The following edits are set to active: • Drug/Drug – soft edit (requires CIO Codes) • High Dose – soft edit (requires CIO codes) • Overutilization (early refill) – hard edit (requires Prior Authorization) • Therapeutic Duplication – hard edit (requires Prior Authorization) The following edits are available in MMIS but currently set to inactive: • Additive Toxicity • Drug/Age-Geriatric • Drug/Age-Pediatric • Drug/Allergy • Drug/Disease • Drug/Pregnancy • Excessive Duration of Therapy • Ingredient Duplication • Insufficient Duration of Therapy • Low Dose • Underutilization (late refill)
3.09.015	The Vendor shall provide a report to the Agency on a monthly and annual basis of the potential utilization and dispensing problems resulting from the following edits: The following edits are set to active: • Drug/Drug – soft edit (requires CIO Codes) • High Dose – soft edit (requires CIO codes) • Overutilization (early refill) – hard edit (requires Prior Authorization) • Therapeutic Duplication – hard edit (requires Prior Authorization) The following edits are available in MMIS but currently set to inactive: • Additive Toxicity • Drug/Age-Geriatric • Drug/Age-Pediatric • Drug/Allergy • Drug/Disease • Drug/Pregnancy • Excessive Duration of Therapy • Ingredient Duplication • Insufficient Duration of Therapy • Low Dose • Underutilization (late refill) Monthly reports are due to the Agency within five (5) days from the end of the month. Annual reports are due to the Agency no later than the first business day in December.
3.09.016	The Vendor shall comply with CMS DUR reporting requirements for all DUR function monthly and annual reports.
3.09.017	The Vendor shall provide on-line real-time response to providers resulting from Pro-DUR reviews.

New #	Drug Utilization Review Requirements
3.09.018	The Vendor shall allow on-line real-time submittal of claims with Conflict/Intervention/Outcome Codes (CIO) and/or prior authorization from providers. The current DUR Outcome Reject Codes document is located in the Procurement Library. The Vendor shall provide on-line real-time approval/denial of claims submitted by providers with appropriate/acceptable Conflict/Intervention/Outcome Codes (CIO) and/or prior authorization.
3.09.019	The Vendor shall provide interface capability to provider computer systems via the Point of Service/Electronic Claims Submissions system.
3.09.020	The Vendor shall provide an on-line user manual to instruct Agency staff on the DUR functionality. The Vendor shall maintain the on-line user manual to reflect current system functions. The Vendor shall provide hands-on user training for a minimum of twenty-four (24) Agency staff monthly or as requested by the Agency.

3.10 Drug Rebate Requirements

Federal regulations require that drug manufacturers enter into an agreement with CMS to provide rebates for their drug products paid for by Medicaid. Manufacturers that do not sign an agreement with CMS are not eligible for Federal Medicaid coverage of their product(s). Manufacturers who sign the CMS Medicaid drug rebate agreement must report their Average Manufacturer Price (AMP) and their Best Price (BP) to CMS on a quarterly basis. CMS uses the AMP and BP to calculate the unit rebate amount. CMS then compiles the manufacturer pricing information into an electronic file, and the unit rebate amount is then sent to state Medicaid drug programs.

The Agency uses the unit rebate amount provided on the CMS electronic file, along with their utilization data, to generate their drug rebate invoices in a CMS approved format. In order to receive rebates from the Manufacturers, the Agency must submit utilization data on a quarterly basis to each manufacturer and CMS. The data must identify, by National Drug Code (NDC) number, the number of units paid for by the Agency of each covered outpatient drug.

The manufacturer is required to pay the invoice, less any disputed amount, within 38 calendar days from the postmark date on the invoice. Failure to pay in the required time frame results in the potential accrual of interest liability.

The Drug Rebate Subsystem maintains the information to carry out the federal mandates related to drug rebate processing. Functions include:

- Maintenance and update of rebate and drug reference data
- Generation of invoices to drug manufacturers
- Application of correction/adjustments to invoices
- Drug rebate accounting and reconciliation
- Collections correspondence and tracking
- Dispute resolution and tracking
- Interest assessment and

- Reporting

The following are the requirements identified by the Agency that must be met by the Vendor to support the successful operation of the Drug Rebate related functions.

New #	Drug Rebate Requirements
3.10.001	The Vendor shall provide the capability to process and track supplemental program drug rebates the same as the federal program but use rebate per unit amounts calculated and provided by the Agency rather than the amounts provided by CMS. These updates shall occur at the same time as the CMS Quarterly update file is processed.
3.10.002	The Vendor shall update a drug manufacturer data set with data from the CMS Quarterly update file within twenty-four (24) hours of receipt.
3.10.003	The Vendor shall update all effective date spans on the drug manufacturer records as required by CMS within twenty-four (24) hours of receipt of the CMS Quarterly update file. The Vendor shall make this data available for on-line and real-time access.
3.10.004	The Vendor shall maintain on-line real-time access to all quarters of drug rebate/invoice information to accommodate prior period adjustment processing as required by CMS.
3.10.005	The Vendor shall maintain and provide accommodations for housing of all correspondence from manufacturers and make available all drug rebate files requested by the Agency within five (5) days of the request.
3.10.006	Agency approval is required on the format of all outgoing correspondence prior to being sent.
3.10.007	The Vendor shall maintain and supply a list of all types of outgoing correspondence prior to implementation.
3.10.008	The Vendor shall notify the Agency of receipt of all CMS rebate-related information within two (2) days of receipt.
3.10.009	The Vendor shall utilize the quarterly file from CMS to update the drug rebate information prior to generating quarterly invoices.
3.10.010	The Vendor shall produce a report of all NDC's added as a result of the update by the 5th day of the month following quarter end as part of the update process.
3.10.011	The Vendor shall provide the capability to exclude specified drugs from drug rebate information processing based on Agency-defined criteria within five (5) days of request.
3.10.012	The Vendor shall download and maintain information from the CMS website to identify and exclude public health service entities one week prior to invoicing.
3.10.013	The Vendor shall ensure that Federal and Supplemental invoices are generated on paper or in electronic media as requested by manufacturer within two (2) days of the request. Each invoice shall be available in paper format for those labelers that cannot utilize an electronic format.
3.10.014	The Vendor shall generate the federal and supplemental invoices in NDC sequence based on the CMS established format. The Vendor shall mail the Agency approved cover letter with the labelers Invoice to the invoice Contact within sixty (60) calendar days of the end of the

New #	Drug Rebate Requirements
	calendar quarter. Receipt of a late file from CMS will be noted by the Agency.
3.10.015	The Vendor shall create drug rebate accounts receivable systematically when the drug manufacturer invoices are produced. This information shall be accessible on-line.
3.10.016	The Vendor shall maintain original and corrected invoice information at the NDC level on-line and real-time.
3.10.017	The Agency will be mailed a dummy invoice and collection letter at the time the invoicing and collection letters are sent by the Vendor. This is to verify the timelines are met.
3.10.018	The Vendor shall respond to all drug manufacturer inquiries regarding drug rebate billing within two (2) days of receipt.
3.10.019	The Vendor shall ensure the system cross-walks specified J-Codes to NDCs per CMS requirements at the time of invoicing. The Vendor generated invoices shall utilize the NDCs.
3.10.020	The Vendor shall provide on-line capability for inclusion of unit type conversion factors for drug unit type mismatches between the physician & pharmacy claim unit types paid and the drug manufacturer unit rebate amount types on the CMS rebate file.
3.10.021	The Vendor shall, by the 5th day of the month following quarter end, produce a report of all NDCs terminated as a result of the CMS Quarterly update file.
3.10.022	The Vendor shall use the NDC termination date from the CMS Quarterly update file to ensure that claims submitted after the termination date are not paid by systematically removing the NDC from coverage as of the termination date. The Vendor shall identify and report to the Agency all NDCs that have been removed from coverage due to an update of the NDC termination date no later than the 5th day of the month following quarter end.
3.10.023	The Vendor shall provide the capability to remove from coverage all NDCs for labelers identified as terminated from the rebate program on the CMS Quarterly update file as of the termination date. The Vendor shall identify and report to the Agency all NDCs that have been removed from coverage due to an update of the file no later than the 5th day of the month following quarter end.
3.10.024	The Vendor shall produce a quarterly report of invoices with any unit rebate amounts of zero no later than the 5th day of the month following quarter end.
3.10.025	The Vendor shall produce a report no later than the 5th day of the month following quarter end to identify any NDC where the drug rebate amount invoiced is greater than the reimbursed amount for the NDC.
3.10.026	The Vendor shall provide the capability to systematically determine the amounts of rebates due from each manufacturer. Factors to be used to determine the rebates shall include but not be limited to NDC codes, drug quantity units on paid physician and pharmacy claims (both original and adjusted claims), rebate amounts, interest and prior period adjustments, per CMS requirements. This information shall be available on-line and real time.
3.10.027	The Vendor shall provide on-line real-time access to payment and dispute data at an NDC level. The data shall include but not be limited to physician and pharmacy claims, CMS listing of manufacturers with drug rebate agreements, CMS listing of quarterly unit rebate amounts and quarterly rebate invoiced amounts.

New #	Drug Rebate Requirements
3.10.028	The Vendor shall produce a monthly report of accounts receivable information by labeler and invoice period for both the federal and supplemental program no later than the 5th day of each month.
3.10.029	The Vendor shall provide the capability to perform batch and on-line updates to all drug rebate data and maintain an audit trail of the changes.
3.10.030	The Vendor shall produce a quarterly report of all instances where the unit type paid on pharmacy and physician claims is different from those reported on the CMS Quarterly update file. This report shall be available on-line no later than the 5th day of the month following quarter end.
3.10.031	The Vendor shall generate & transmit Agency rebate utilization data to CMS in the format specified by CMS within sixty (60) calendar days of the end of the calendar quarter.
3.10.032	The Vendor shall generate and mail follow-up letters to non-responding manufacturers forty-five (45) calendar days from mailing date of the invoice.
3.10.033	The Vendor shall receive, process and track rebate and interest payments received from drug manufacturers within ten (10) days of receipt from the Agency.
3.10.034	The Vendor shall produce a daily report by labeler and invoice of all payments that have not been fully posted.
3.10.035	The Vendor shall provide on-line real-time capability to retrieve all payments and interest posted in a specified time period to show, by labeler and quarter, what amounts have been posted and adjusted as well as the beginning and ending balance.
3.10.036	The Vendor shall produce a monthly report of all past due rebate amounts by labeler and invoice period showing the number of days past due for both the federal and supplemental program no later than the 5th day of each month.
3.10.037	The Vendor shall produce a monthly report of all payments and interest received for both the federal and supplemental programs no later than the 5th day of each month.
3.10.038	The Vendor shall provide the capability to recalculate on-line real-time invoices if the rebate per unit changes at posting of check or if the amount the manufacturer submits is different from the invoice and judged to be correct at the time of dispute resolution.
3.10.039	The Vendor shall review all drug manufacturer correspondence to identify and establish dispute-related information within two (2) days of receipt of correspondence.
3.10.040	The Vendor shall provide on-line real-time paid claims data in an electronic format that can be exported into a spreadsheet type document for a specified NDC for a specified quarter.
3.10.041	The Vendor shall establish a dispute when the amount paid differs from the amount due because of unit discrepancy within two (2) days of check posting.
3.10.042	The Vendor shall maintain an on-line real-time drug rebate dispute tracking system. This system shall track by labeler, invoice period and invoice type the following information: labeler name, date received, analyst assigned, NDC, drug name, rebate amount per unit, CMS unit of measure, total units reimbursed, total rebate amount claimed, total units paid, total rebate amount paid, Agency adjusted units, new rebate amount claimed, balance of units, rebate

New #	Drug Rebate Requirements
	balance due, reason code, resolution code and dispute status.
3.10.043	The Vendor shall maintain on-line real-time the capability to search paid claims by NDC and quarter for pharmacy and physician claims with hyperlinks to the provider information and the claim information.
3.10.044	The Vendor shall receive and process requests from manufacturers for paid claims detail to support drug rebate invoices. Paid claims detail reports for utilization after the third quarter 1999 shall be produced by the vendor and provided to the manufacturer within ten (10) days of receipt of the request. Paid claims detail reports for utilization prior to the fourth quarter 1999 will be produced and supplied to the Vendor by the Agency. The Vendor shall provide the report to the manufacturer within two (2) days of receipt from the Agency.
3.10.045	The Vendor shall notify the Manufacturer of dispute resolution within two (2) days of resolution.
3.10.046	The Vendor shall correspond with providers to obtain supporting documentation for claims billed that are identified in the dispute resolution process within five (5) days of the request.
3.10.047	The Vendor shall produce a report by the 5th day of the month that contains disputes established or closed within the previous Month. The Vendor shall produce a report by the 5th day of the month that contains all open disputes.
3.10.048	The Vendor shall produce a monthly report of labelers with the highest dispute amounts for both the federal and supplemental program no later than the 5th day of each month.
3.10.049	The Vendor shall provide a process for requesting claim adjustments within the Claims subsystem so that adjustments occur within five (5) days of the request.
3.10.050	The Vendor shall obtain and input on the first business day of each week the Treasury Bills rates as specified by CMS. The Vendor shall maintain all history of Treasury Bills rates on-line real-time.
3.10.051	The Vendor shall notify the manufacturer of interest due on late payments at the time the check is posted. The Vendor shall calculate the interest using the CMS specifications.
3.10.052	The Vendor shall provide quarterly drug rebate information in a format compatible with CMS-64 reporting requirements within five (5) days of the end of the calendar quarter.
3.10.053	The Vendor shall create a file containing the data and in the format requested by Data Niche. These files shall be produced and sent to Data Niche within five (5) days of the request.
3.10.054	The Vendor shall provide support including but not limited to account information and supporting claim data to the Agency within five (5) days of request.

3.11 Long Term Care (LTC) Requirements

The primary purposes of the Alabama Medicaid Long Term Care (LTC) programs are to serve recipients in need of LTC services in the least restrictive environment, to reimburse providers in

an equitable manner, to monitor utilization for appropriateness and to assure recipients access to services from the Medicaid program. The LTC program supports the processing of medical approvals submitted through the LTC Notification software from LTC facilities, Hospice providers, and waiver providers for recipients who are found financially and medical eligible for long term care or waiver services. LTC Notification software interfaces with the AMMIS for the tracking and processing of claims, rate adjustments, payments and management information regarding the utilization of services.

The following are the requirements identified by the Agency that must be met by the Vendor to support the successful operation of the Long Term Care related functions.

New #	Long Term Care Requirements
3.11.001	The Vendor shall be responsible for the maintenance and support of the LTC Notification Software and shall distribute to providers at no charge.
3.11.002	Generate annual CMS-372 Lag report for each HCBS waiver program. The reports are to be produced the first day of the 16th month after the end of the waiver year. The Elderly and Disabled (E&D) Waiver, Living at Home Waiver (LAHW), Mental Retardation (MR) Waiver, HIV-AIDS Waiver ends on September 30th. The Technology Assistance (TA) Waiver year end is February 22nd. State of Alabama Independent Living (SAIL) Waiver year end is March 31st. The report must meet all CMS & federal reporting requirements including the requirements stated in the State Medicaid Manual.
3.11.003	All State Agencies and Providers except Hospice providers shall have access to the Medicaid LTC Notification software. The Hospice providers will have designated contractors that will access the Medicaid LTC Notification Software. The State Agencies, Providers & Contractors shall only have access to recipients assigned to them. The State Agencies, Providers and Contractors shall have the ability to create new segments and add date of death and start date for recipient segment. The Nursing Home end date for Provider entered segments will default to 12/31/2299. The end date for all Waivers segments is the last day of the month entered plus one year from the start date of the segment. The Waiver Providers may not change the segment end date to a date greater than the end date in the system.
3.11.004	The Vendor shall provide the capability for providers to download the LTC Notification Software from the web to their computer. The LTC Notification Software will allow access to LTC data for their assigned recipients.
3.11.005	Maintain on-line, real-time separate rates and the effective date for each rate per facility for all Long Term Care programs. There shall be at least sixty (60) months of data available.
3.11.006	The Vendor shall monitor changes to recipient data, such as eligibility end date and recipient liability amounts or changes in provider rates to identify erroneous claim payments. The Vendor shall retroactively reprocess nursing facility claims when there is such a change. All such reprocessed claims are defined as adjustments and are not subject to administrative reimbursement.
3.11.007	The Vendor shall provide a monthly report of all changes to LTC recipient liability or eligibility end dates. The report shall include but not be limited to recipient ID, eligibility start and end dates, liability amount before change and after change, claim amount before reprocessing, claim amount after reprocessing and adjusted amount. The report shall be produced by the 5th day of the month.

New #	Long Term Care Requirements
3.11.008	The Vendor shall provide a monthly report of provider rate changes. The report shall include but not be limited to provider ID, rate before change and rate after change, the claim amount before reprocessing and the claim amount after reprocessing. The report shall be produced by the 5th day of the month.
3.11.009	The Vendor shall at a minimum provide the following report on a monthly basis: • LTC-0007-M LTC and Waiver Monthly Activity reports The Vendor shall provide the report by the 5th day of the end of each month and store in COLD.
3.11.010	The Vendor's LTC Notification Software shall accept electronic applications from State Agencies, providers and contractors. The LTC Notification software shall execute Agency defined edits on the application to determine acceptance or rejection. The application status shall be available to the provider through the LTC Notification Software within one (1) day.
3.11.011	The LTC Notification Software shall store thirty-six (36) months of data. The data shall be available on-line real-time accessible by recipient ID and name. The data shall include, but not be limited to: Admission and discharge dates, Financial and medical application data, Therapeutic leave days and the data needed to support claims processing and reporting.
3.11.012	The MMIS shall allow on-line real-time updates to recipient data.
3.11.013	The Vendor shall provide the capability to support retroactive rate adjustment processing. Monthly by the 5th day, the Vendor shall reprocess nursing facility claims with changes in patient liabilities or individual nursing facility rates. The Vendor shall not adjust any claims older than six months.
3.11.014	The Vendor shall limit claim payment for recipient therapeutic leave days. Nursing facility residents are allowed six (6) therapeutic visits per calendar quarter not to exceed twenty-four (24) visits per calendar year. Each therapeutic visit must not exceed three (3) days. ICF/MR therapeutic leave days are limited to fourteen (14) days per calendar month.
3.11.015	The system shall receive and apply files from the State or other regulatory boards and agencies, including but not limited to: the Alabama Department of Mental Health/Mental Retardation, Alabama Department of Public Health, Alabama Department of Senior Services and Alabama Department of Rehabilitative Services. The data shall be validated before being applied to the LTC files and error reports shall be produced for any data that is not valid or cannot be applied to the system.
3.11.016	The Agency shall have on-line real-time update capabilities to the data in the Long Term Care software.
3.11.017	The Vendor shall link nursing home provider information to the recipient so that changes to the name and address on the nursing home provider file are updated in the recipient's information.
3.11.018	The Vendor shall generate and deliver to Medicaid all LTC recipient reports as identified in the Alabama MMIS Reports Listing located in the Procurement Library.
3.11.019	The Vendor shall provide On-line, real-time update capability to MMIS recipient data.

New #	Long Term Care Requirements
3.11.020	The Vendor shall update the LTC Notification Software data with nightly updates.
3.11.021	The Vendor shall update the MMIS data with changes made in the LTC Notification Software data daily.
3.11.022	The Vendor shall support the interface of the LTC Notification Software with the MMIS Recipient and Provider data as part of the validation process for LTC applications.
3.11.023	The LTC Admission Notification Software shall only accept the Provider NPI. The NPI shall be validated and edited against the provider contract information to ensure the request is for an active Medicaid Provider that is authorized to provide LTC services.
3.11.024	The LTC Admission Notification Software, Admission Notification screen, Submission Reason drop down box should be modified. Generate a weekly report for certifying agent D case by district office number, reviewer number, and option selected from the number 7 drop down box.
3.11.025	For the HIV/AIDS Waiver. Request to the Eligibility Group to add eligibility recipients receiving SSI deemed to be receiving SSI and optional categorically needed at a special income level of 300% of FBR, State Supplementation, recipients eligible for the Pickle program (continued Medicaid); deemed disabled widow and widowers from age 50 but not yet 60; early widow and widowers 60-64; disabled adult children that lose supplemental income benefits upon entitlement to or an increase in the child's insurance benefits base on disability; those individuals who would be eligible for SSI if not deeming of income of parents (s) or spouse; and Medicaid for low income families (MLIF).
3.11.026	The Benefit Plan from the Level of Care data is needed for informational and processing purposes to know which waiver to use for the LTC-Type on AMAES. Add Level of Care Benefit Plan to the nightly extract to AMAES so Medicaid's program (MSRE027) can put in the corrected LTC-Type on AMAES. Agency points of contact are Lee Rawlinson, Marilyn Chappelle, Ozenia Patterson, Robin Arrington, Betty Payne and Susan Jones.
3.11.027	This request is being made to correct a processing problem between the Agency and EDS Interchange so Interchange will recognize retro eligibility segments by Program Codes.
3.11.028	The Vendor shall provide on-line user manuals to instruct Agency staff on the LTC MMIS subsystem and LTC Notification Software. The Vendor shall maintain the on-line user manuals to reflect current system functions. The Vendor shall provide hands-on user training for a minimum of twenty-four (24) Agency staff monthly or as requested by the Agency.
3.11.029	The Vendor shall at a minimum provide the following reports on a daily basis (Current Report Title has an M): • LTC-0005-M LTC Notifications not accepted and reason not accepted • LTC-0006-M Notification accepted and written to file • LTC-0008-M Trading Partner Activity Report The Vendor shall make the reports available by 7 AM and store in COLD.

New #	Long Term Care Requirements
3.11.030	The Vendor shall ensure the LTC Notification software program will write reason code(s) and comments for discharges to the recipient's LTC segment. The LTC DO nightly update currently creates a log which contains open-ended segments. This CSR will assist LTCPM0010 program in locating discharges that open end incorrectly. It should not open end segments for those which have a discharge.

3.12 Managed Care Requirements

The Managed Care function is designed to allow the Agency the ability to develop and implement various managed care systems to ensure recipient access to necessary medical care, while at the same time controlling medical assistance program costs. Currently the Agency uses a combination of PCCMs, PIHPs and Medicare Advantage Plans. Through each of these programs recipients are assigned primary medical providers or primary contractors who are responsible for managing healthcare needs. Though designed to be comprehensive in meeting patient needs, payment does not include all services that may be provided. As a result, the managed care system must support both capitation, global and fee for service payment options. Under such models, the state has developed a network of PCP/CMs who are contracted to provide medical services to Medicaid program recipients. Recipients receive services included in the Alabama Medicaid Patient 1st Program. In addition, recipients receive pharmacy and certain other wrap-around services outside of the managed care plan. The objectives of each managed care program are:

- Increased recipient access to healthcare,
- Increased use of case management and preventive services, and
- Optimal patient outcomes.

The Managed Care has the following main areas:

- Recipient enrollment and eligibility in the various plans.
- Provider enrollment for both PCCM's and MCO's.
- Auto-assignment of eligible recipients into the plans.
- Capitation Payment information.
- Enrollment Roster information.
- PMP Mass Disenrollment and/or Transfer of Panels.
- PMP Mass Transfer and Release of Panels.

The following are the requirements identified by the Agency that must be met by the Vendor to support the successful operation of the Managed Care related functions.

New #	Managed Care Requirements
3.12.001	The Vendor shall ensure that no capitation payments are made for Mental Health programs.
3.12.002	The Vendor shall make capitated payments for voluntary enrollment in Medicare HMOs in selected counties.
3.12.003	The Vendor shall provide the capability to assign providers to managed care recipients.
3.12.004	The Vendor shall provide the capability on-line real-time to enter a recipient id and search availability of managed care providers and update provider assignment.
3.12.005	The Vendor shall provide a web application that allows the recipient to review the availability of managed care providers based on recipient ID and Provider enrollment criteria such as but not limited to number of patient or provider's proximity to recipient's location.
3.12.006	The Vendor shall provide the Managed Care Providers a list of assigned recipients each month after the recipient monthly update. The list is use by the providers to identify their patients. Any provider assignments made after the recipient monthly update will not appear on the list and the effective date shall be for the following month.
3.12.007	The Vendor shall use the Alabama Medicaid algorithm guidelines for assigning Managed Care Providers. The available providers are currently assigned by newborn, siblings, past PMP, claims history and proximity. The Vendor shall apply the algorithm to unassigned managed care recipients using a PMP Assignment batch process that shall run monthly after the monthly recipient update. The Managed Care provider assignment will be effective the month following the month of the PMP Assignment run. For example if the providers are assigned the 20th of April, the assignment will be effective the first of June. The newborn, sibling, and past PMP assignment process will override the PMP's max caseload under designated circumstances.
3.12.008	The Vendor shall only allow recipients to be assigned to Patient first if they meet the following specified criteria. The recipient must; - reside in Alabama; - reside in a county that is eligible for Patient 1st (01-67); - be alive; - be eligible for Medicaid; - not have an aid category 3A (breast /cervical cancer); - have an (Aid Cat that begins with "1","2","3", "4", "6", or "N" Or (Aid Cat must be 51,52,54,55,5D,5E, or 5N (SOBRA) and Adult/Child Indicator = C); - NOT be a participant in LOCKIN; - have a blank PCCM exemption indicator on the recipient file; - NOT have a First name equal to "UNBORN"; - NOT have an active segment on the LTC file; and - NOT have an "HMO" policy on the TPL file- TPL plan code of "H".

New #	Managed Care Requirements
3.12.009	The Vendor shall provide the capability for recipients to submit a newborn form designating their PMP choice. Upon receipt of the form the Vendor shall assign the managed care provider identified on the newborn form regardless of any other criteria. The Vendor shall make the provider assignment within three (3) days of receipt of the form. The Vendor shall provide the capability to make PMP assignments for both newborn and unborn babies. The Vendor shall have the ability to use an override to make the PMP assignment effective the first of the following month. If no form is submitted, the Vendor shall assign the PMP using the Alabama Medicaid algorithm guideline for assigning providers.
3.12.010	The Vendor shall provide the capability for managed care recipients to request provider assignment changes through the recipient call center. The changes shall be made on-line real-time but the effective date will be based on the recipient monthly update process.
3.12.011	The Vendor shall produce monthly Patient First Reports to the Agency and PMPs, of recipient enrollment. The report shall be produced after all monthly updates to managed care data. The Vendor shall ensure providers are only provided access to information on recipients assigned to them. The report shall be mailed to the providers prior to the first of the month. The reports provided shall include but are not limited to: PCCM Provider Referral Report Patient 1st Roster Newborn Summary Report Newborn Error Report Capitation Payment Report The Vendor shall provide secured Web access to providers for the viewing and download of the following reports: Patient 1st Roster Capitation Payment Report.
3.12.012	The Vendor shall send the recipient an Initial Assignment Letter (packet) within five (5) days of the completion of the batch assignment process. The Vendor shall notify the Agency's patient first program with the date and number of letters mailed within one (1) day of the completion of the batch assignment process.
3.12.013	The Vendor shall send the recipient a reassignment letter or auto-assignment letters when there are changes in the PMP enrollment status within two (2) days of the enrollment change. The Vendor shall notify the Agency's patient first program with the date and number of letters mailed within one (1) day of the completion of the batch assignment process.
3.12.014	The Vendor shall produce and mail Patient 1st Reminder Postcards thirty (30) days after the initial assignment letter.
3.12.015	The Vendor shall send the Patient 1st Recent-Recert Postcards (in place of the Initial Assignment Letter [Packet]) for recipients that have less than a sixty (60) day gap in eligibility within two (2) days of the completion of the batch assignment process.
3.12.016	The Vendor shall produce and mail Patient 1st Annual Reminder Postcards within two (2) days of the recipient’s certification anniversary.

New #	Managed Care Requirements
3.12.017	The Vendor shall produce a list of Patient 1st providers by county and include in the Initial Assignment Letter (packet). The Vendor shall mail the list to the recipients when requested within two (2) days of the request. The Vendor shall provide the Patient 1st providers by county listings to the Agency by the 5th of each month.
3.12.018	The Vendor shall obtain Agency approval for all correspondence or modification to correspondence before use.
3.12.019	The Vendor shall maintain case management fee processing data. The data shall contain current and history case management components with start dates, end dates, and amounts. The Vendor shall base the case management fee on the active entries at the time of processing. The Vendor shall provide on-line real-time search and update capability to case management data.
3.12.020	The Vendor shall ensure that Managed Care recipients are identifiable in DSS so that Agency can do add hoc reporting as needed.
3.12.021	The Vendor shall produce a DSS Emergency Room Management Report on a quarterly basis by the 5th of the month following quarter end. The report shall contain a list of the provider's recipients with emergency room services for the quarter. The Vendor shall mail the report to each provider within two (2) days of producing the report. The Vendor shall store a copy of the quarterly Emergency Room Management Report in COLD. The report shall also be available for ad-hoc reporting with selectable criteria including but not limited to: DOS range, age, number of visits, provider and diagnosis.
3.12.022	The Vendor shall provide on-line real-time access to the accumulated totals of managed care recipients assigned to each provider, including the plan and proximity served.
3.12.023	The Vendor shall provide on-line real-time access to Managed Care external health plan information from other subsystems such as TPL.
3.12.024	The Vendor shall have a designated provider enrollment staff for forty (40) hours a week to assist managed care providers. The Vendor shall track all calls received, all inquiries or issues shall be resolved in one (1) day or the call documentation updated on a daily basis to resolution. All issues or inquiries open over fifteen (15) days shall be reported to the Agency monthly by the 5th day of the month.
3.12.025	The Vendor shall add and/or end date capitation rates on-line real-time for initial enrollment, a change in enrollment, or at the request of Patient 1st staff. The updates or changes received by phone shall occur the day of the call. The updates or changes received by mail, fax or e-mail shall occur within two (2) days of receipt and an Agency approved letter of acknowledgement shall be sent to the provider within three (3) days of receipt. The Vendor shall acknowledge the Patient 1st staff's requests for changes to capitation rate via email when updates are complete.
3.12.026	The Vendor shall provide a report on all patient 1st current capitation rates for each provider including the average case management fee by month and store in COLD.
3.12.027	The Vendor shall mail an Initial Assignment Letter (packet) to recipients new to the Patient 1st program or a recipient that has re-enrolled after a sixty (60) day or greater gap in service.

New #	Managed Care Requirements
3.12.028	The Vendor shall generate and mail an Initial Assignment Letter (packet) to Managed Care beneficiaries notifying them of their PMP assignment and effective date, forty-five (45) days prior to the effective date of assignment. The packet shall include but is not limited to: - a letter identifying the assigned PMP's name, physical address, telephone number, and Instructions on how to change PMP - a list of available providers within their proximity - a pamphlet that educates the recipient on emergency room use - a pamphlet containing the recipient's rights and duties as a Patient 1st recipient - a "Your Guide to Patient 1st" booklet
3.12.029	The Vendor shall run the auto-enrollment program on a monthly basis. The Vendor shall identify and assign PMPs to the following: - newly eligible recipients without an active current PMP assignment - recipients who move into a different zip code area - recipients who move into an included aid category - recipients whose private HMO coverage has ended The Vendor shall give recipients until the 15th of the month (after a full calendar month) to change PMPs. The Vendor shall make PMP changes by telephone, mail or fax until the recipient monthly update occurs.
3.12.030	The Vendor shall execute the auto-disenrollment process to end date the patient 1st eligibility for recipients who: - lose Medicaid eligibility - have a change in zip code - enroll in a private HMO or managed care plan - are changed to an excluded aid category. The Vendor shall not assign a provider to recipients who have changed zip code until the next monthly auto-assignment. The Vendor shall update the PMP file to show the current caseload.
3.12.031	The Vendor shall verify any reports, within two (2) days, of PMP's that are no longer available. If the PMP is not available, the Vendor shall notify Patient 1st of their findings within two (2) days. Patient 1st will make a decision on the re-assignment of all recipients assigned to providers that are not available. The Vendor shall make the provider assignment as directed by Patient 1st.
3.12.032	The Vendor shall accept a letter or fax (phone calls must be followed up with a letter or fax) from PMP providers that no longer wish to participate in the Managed Care program. The Vendor shall enter the provider information in the managed care PMP mass dis-enrollment panel with a status of pending and add the providers to a weekly dis-enrollment report. The Vendor shall produce a dis-enrollment report that contains all providers dis-enrolled that week and any disposition of the recipient such as auto-assignment or re-assignment. The Vendor shall e-mail the dis-enrollment report to Patient 1st on Friday of each week. Patient 1st shall approve the dis-enrollment by updating the status in the PMP mass dis-enrollment

New #	Managed Care Requirements
	panel. The Vendor shall indicate provider dis-enrollment that will generate a letter. If Patient 1st disagrees with the letter indicator they will contact the Vendor to make a change.
3.12.033	The Vendor shall accept a letter or fax (phone calls must be followed up with a letter or fax) from PMP providers that wish to make changes in their Patient 1st enrollment criteria. The Vendor shall enter the provider information in the managed care PMP mass transfer panel with a status of pending and produce a weekly dis-enrollment report. The dis-enrollment report shall contain all PMP providers with changes to their enrollment criteria that week and any disposition of the recipient such as auto-assignment or re-assignment. The Vendor shall e-mail the report to Patient 1st on Friday of each month. Patient 1st shall approve the changes in enrollment criteria by updating the status in the PMP mass transfer panel. The Vendor shall indicate provider mass transfers that will generate a letter. If Patient 1st disagrees with the letter indicator they will contact the Vendor to make a change.
3.12.034	The Vendor shall allow recipients to change PMPs after initial assignment. The Vendor shall make changes in PMP by the 20th of the month to be effective by the first of the following month.
3.12.035	The Vendor shall support the auto-assignment process for claims history by reviewing 18 months of the recipient claims data. The system shall "count" the number of visits a recipient has in history to a particular PMP. For example, if the recipient visits Dr. Smith (Group A) two (2) times, Dr Wilson (Group A) three (3) times, and Dr. Thomas (Group B) four (4) times, they would be assigned to Dr. Wilson (Group A).
3.12.036	The Agency may lock-out recipients from a provider. If this occurs the Vendor shall not allow the auto-assignment process to assign the recipient to the locked out PMP or any PMP in the same group.
3.12.037	The Vendor shall dis-enroll any recipient with active Medicare Buy-in segment dates when identifying recipients who should be included/excluded from participation in the managed care programs. The Vendor shall make the dis-enrollment date from managed care the last day of the month before the Medicare enrollment date.
3.12.038	The Vendor shall produce and mail Provider Referral Reports by the 5th of the month following quarter end. This report shall contain all referrals on recipients assigned to the provider for the quarter.
3.12.039	The Vendor shall produce and mail Provider Profiler reports on an Agency defined schedule and reporting periods. The reports shall be made available on a common media for Patient 1st review prior to mailing. The Vendor shall, after Patient 1st approval, mail to the provider within 5 days and send a copy of the reports to Patient 1st on CD or DVD.
3.12.040	The Vendor shall make all managed care reports available in paper and electronic format.
3.12.041	The Vendor shall provide the capability to identify procedure codes that require a Patient 1st referral. The Vendor shall process claims edits that prevent the payment of claims when the procedure code requires a referral but the assigned PMP's NPI number is not the referring physician.
3.12.042	The Vendor shall provide Agency selected staff the capability to input override codes that will allow claims to be paid without a referral number when the procedure code indicates referral is required.

New #	Managed Care Requirements
3.12.043	The Vendor shall provide monthly reports of activities, issues, trends, and recommendations regarding managed care policies, procedures, and focus areas. This includes but is not limited to the PMP Referred/Authorized Services Report and the PMP Change Report. The reports are produced quarterly and shall be available by the first of the month following quarter end.
3.12.044	The Vendor shall distribute provider and recipient notices that are prepared by the Agency within five (5) days of the request.
3.12.045	The Vendor shall electronically store all provider contracts and amendments. This information shall be available for on-line viewing in COLD.
3.12.046	The Vendor shall be responsible for maintaining covered services, non-covered services and benefit limits. This Vendor shall use system maintenance hours for these changes.
3.12.047	The Vendor shall maintain provider characteristics for each managed care program. Characteristics include but are not limited to PMP, Mid-level associates' name, academic indicator, 24-hour phone number, county enrollment, proximity, age range limits, current/max caseloads, beginning and end dates, list (published) and Patient 1st Case Management Fee information. This information shall be updatable and searchable on-line real-time.
3.12.048	The Vendor shall utilize the Enrollment Data Base (EDB) to determine the recipients that are enrolled with a contracted Medicare Advantage Plan. There are also plans that submit a list of recipients to be excluded from the capitation payments. The Vendor will use the list of active recipients enrolled in the Medicare Advantage plan to generate capitation payments to each contracted Medicare Advantage Plan. This will occur monthly as part of the managed care capitation payment processing.
3.12.049	The Vendor shall generate the Patient 1st Roster to consist of four sections: Pending assignments, new assignments, continuing assignments and terminated assignments. The report shall contain all data related to the PMP criteria including but not limited to case load, case management fee and special panel conditions. These reports shall be created after the monthly updates to managed care. The providers shall have the report by the 1st of the month. The report shall be available to providers through the provider Web portal.
3.12.050	If the provider is a member of a group, the Vendor shall allow a referral from another provider in the group to be processed as a referral from the assigned provider.
3.12.051	The Vendor shall deny Medicare covered claims using assigned EOB codes for recipients enrolled in a Medicare Advantage Plan in which the managed care plan receives a capitation payment.
3.12.052	The Vendor shall maintain the capability to accept claims for a Patient 1st referring provider for six (6) months after a change in PMP.
3.12.053	On the first check write of each month, The Vendor shall generate case management payments for each enrolled recipient to their assigned PMP. The Vendor shall make payments to the group provider of an individual PMP whenever that individual PMP is part of a group. The Vendor shall make payments on the first checkwrite of each month and report on the PMP's remittance advice (RA).

New #	Managed Care Requirements
3.12.054	The Vendor shall receive recipient information from the Alabama Medicaid Recipient System. This is defined in detail in the requirements for the Recipient system.
3.12.055	The Vendor shall process Fee-for-service claims and encounter data, including EDI claims for CMS-1500, UB-04, NCPDP, dental, EPSDT and family planning.
3.12.056	The Vendor shall ensure, as appropriate, that each recipient's cost/utilization data is linked to their managed care program and their PMP for use in managed care reporting.
3.12.057	The Vendor shall provide the capability to enroll family members into different and/or the same managed care program. The Vendor shall allow one member of a household to be enrolled in a commercial HMO, while the remainder of the family is enrolled in managed care. The Vendor shall apply this same requirement to individual family members who are exempt or excluded from managed care.
3.12.058	The Vendor shall maintain a repository of basic managed care plan contracts and contract data in addition to information identifying specific providers and networks, capitation rates, benefit packages and geographic areas for each plan in order to process encounter data, stop-loss claims, capitation payments and retroactive payment adjustments.
3.12.059	The Vendor shall provide a payment function for processing capitation claim(s) and issuing monthly capitation payments and supporting RAs for each prepaid managed care plan which must report through the MMIS Financial functional area.
3.12.060	The Vendor shall provide a function for processing and issuing a monthly case management fee and supporting RA for each managed care provider. This information shall be mailed to the provider after the first checkwrite of each month and stored in COLD.
3.12.061	The Vendor shall Provide the capability to distribute funds to the appropriate plans based on different reimbursement arrangements, capitation rates, categories and rules for each benefit package.
3.12.062	The Vendor shall provide the capability to reject normal FFS claims for covered services rendered by capitated plans. The Vendor shall provide the capability to process FFS claims not covered in the capitated plan.
3.12.063	The Vendor shall calculate and pay case management fees to providers for each managed care enrollee assigned to them up to the limitations specified by the Agency.
3.12.064	The Vendor shall maintain recipient data/enrollments in contracted managed care plans. The data will be used for the following and shall include but not be limited to: - Case management/capitation/premium computations - Referral processing for the Managed Care program - Encounter processing (claims and/or vital claims elements) - Administrative, utilization review, financial and QA reporting
3.12.065	The Vendor shall set/save all capitation rates and provide on-line real-time update capability. The Vendor shall modify the rates and systematically process adjustments upon Agency request.
3.12.066	The Vendor shall allow the same provider to be paid FFS, case management and capitation concurrently for different enrollees/recipients.

New #	Managed Care Requirements
3.12.067	The Vendor shall generate adjustments to post capitation rates based on retroactive adjustments to recipient or managed care provider information including enrollment periods, changes in rate categories, contracted rates and recipient death.
3.12.068	The Vendor shall provide through DSS the data for services rendered by providers who have contracted with managed care entities in order to determine the payments which the Agency would have made for these services if they had been rendered on a fee for service basis.
3.12.069	The Vendor shall incorporate a prospective monthly disbursement function which includes the following: Production of capitation/Managed Care payments to capitated providers and managed care plan Production of a roster of enrollees assigned to each capitated/Managed Care provider and managed care plan in both electronic and paper form Production of a remittance advice which describes the reason or type of each capitation transaction Production of a report which summarizes the amounts included in each unique capitation payment
3.12.070	The Vendor shall provide an automated adjustment function that recoups or pays retroactive capitation payments and produces a report of all adjustments in capitation payments by provider. The Vendor shall provide a report of pending adjustments prior to making adjustments. The adjustments must be approved by Patient 1st before processing the adjustments.
3.12.071	The Vendor shall accept and process encounter claims on-line real-time for services provided by health plans to enrolled recipients
3.12.072	The Vendor shall provide a repository of encounter claims information for each managed care plan. The Vendor shall ensure all federal reporting requirements based on data from encounter records are met. This includes but is not limited to family planning, sterilizations, hysterectomies, pregnancies, EPSDT and immunizations.
3.12.073	The Vendor shall provide the capability to differentiate providers and services covered by a capitation agreement from providers and services outside the capitation agreement
3.12.074	The Vendor shall dis-enroll recipient with a managed care indicator on the Recipient Policy file. The Vendor shall not enroll a recipient in Patient 1st when this indicator is present.
3.12.075	The Vendor shall support non-capitated, fee for service-based provider who supplies, through an ongoing patient/physician relationship, primary care services and referral for all necessary specialty services. The provider is responsible for monitoring the health care and utilization of emergency and non-emergency services.
3.12.076	The Vendor shall support the payment of case management fees to the managed care provider. The Vendor shall base the case management fee on active criteria and allow each criterion to have a start, end date and associated amount. This shall be table driven and changes to the table shall be part of system maintenance hours.
3.12.077	The Vendor shall support the enrollment of recipients in one or more managed care programs, including freedom of choice and/or automatic assignment waiver provisions.

New #	Managed Care Requirements
3.12.078	The Vendor shall Provide for the collection and generation of FFS data details (i.e., charges and fee schedule amounts) for capitated services as the result of the submittal and processing of encounter claims. This information shall be produced monthly by the 5th day of the month.
3.12.079	The Vendor shall produce a Medicare HMO Enrollment Roster of recipients by Medicare Advantage Plan monthly the first working day after the managed care capitation payment processing.
3.12.080	The Vendor shall produce monthly enrollment and participation reports by program and by provider. The report must be able to track new and multiple plans. The report shall be available the first working day after Managed Care capitation payment processing.
3.12.081	The Vendor shall provide monthly a report of PMP case management fee, by group practice or individual PCP, by member/months for each provider by the 5th day of the month.
3.12.082	The Vendor shall dis-enroll recipients from Patient 1st when LTC segments are active.
3.12.083	The Vendor shall use the payee number to identify siblings in the auto-assignment process. The Vendor shall use the payee number and age to differentiate siblings from parents.
3.12.084	The Vendor shall allow a reason code to be assigned that indicates the step in the auto-assignment algorithm that made the provider assignment. The Agency shall have the ability to change current reason codes or add new reason codes.
3.12.085	The Vendor shall allow for dummy provider referral numbers for Patient 1st Programs. The Vendor shall allow a referral override to permit services to be paid without the assigned provider number as the referring provider.
3.12.086	The Vendor shall provide a method that will allow the Agency to generate new letters and modify current letters on-line real-time.
3.12.087	The Vendor shall provide an on-line real-time update capability to add a new county into a managed care program when needed.
3.12.088	The Vendor shall support Medicare Advantage (HMO) enrollment and disenrollment processing requirements.
3.12.089	The Vendor shall provide the ability to update and search recipient related data, such as Managed Care health plan enrollment and primary medical provider assignment. The Vendor shall make manual updates to recipient enrollment within 5 days of Agency request. The Vendor shall process electronic updates from health plans as directed by the Agency.
3.12.090	The Vendor shall provide Medicare HMO Enrollment Summary of Medicare HMO Capitations. This report shall be produced monthly on the first working day after the Managed Care Capitation Processing.
3.12.091	The Vendor shall pay a set capitation fee per recipient for all contracted plans at a rate defined by the Agency.
3.12.092	The Vendor shall automatically recoup capitation payments that are paid in error within the timeframe defined by the Agency.
3.12.093	The Vendor shall allow retroactive capitation payment for use up to three (3) months based on the eligibility criteria and the plan enrollment segments on the EDB file.
3.12.094	The Vendor shall add, delete or update a Medicare Advantage provider and any change to the associated counties they service. This will be handled as system maintenance hours not system modification hours.

New #	Managed Care Requirements
3.12.095	The Vendor shall provide a file to the Agency by the fifth of the month containing the data needed for MSIS managed care reporting. The Agency will specific the data needed as well as the report format.

3.13 Medical Services Requirements

The Medical Services function is designed to allow the Agency the ability to develop and implement various medical service plans to ensure recipient access to necessary medical care, while at the same time controlling medical assistance program costs. Currently the Agency uses a combination of programs such as Maternity care and Partnership Hospital Program. In addition, recipients receive pharmacy and certain other wrap-around services outside of the managed care plan.

The following are the requirements identified by the Agency that must be met by the Vendor to support the successful operation of the Medical Services related functions.

New #	Medical Services Requirements
3.13.001	The Vendor shall not pay capitation payments for Mental health programs.
3.13.002	The Vendor shall accept and process recipient requests for information on prior authorization status or any other recipient type questions.
3.13.003	The Vendor shall have a table for capitation fee processing. The table shall contain current and history capitation fees components with start dates, end dates and amounts. The capitation fee will be based on the active entries at the time of processing.
3.13.004	The Vendor shall ensure the Maternity Care recipients and PHP recipients are identifiable in DSS so that the Agency can do add hoc reporting as needed.
3.13.005	The Vendor shall support the administration of a variety of different service delivery models; including managed care plans agreements and PHP agreements. This support also includes producing, submitting, and revising, if necessary, new or existing reports on a timely basis as necessary to manage the manage care plans.
3.13.006	The Vendor shall provide the capability to identify procedure codes that require a Medical Services prior authorization. There shall be claim edits that prevent the payment of claims when the procedure code indicates a PA is required but there is no PA on file.
3.13.007	The Vendor shall ensure the Medical Services program has the ability to use special override codes that will allow claims to be paid that would normally be denied.
3.13.008	The Vendor shall distribute provider and recipient notices that are prepared by Medicaid within five (5) days of the request.
3.13.009	The Vendor shall be responsible for maintaining covered services, non-covered services and benefit limits. The Vendor shall use system maintenance hours for these changes.
3.13.010	The Vendor shall produce the Medical Services reports defined in the Alabama MMIS Reports Listing located in the Procurement Library.

New #	Medical Services Requirements
3.13.011	The Vendor shall provide the capability to distribute funds to the appropriate Maternity Care plans based on different reimbursement arrangements, categories and rules for each prepaid inpatient health plan and benefit package. The Agency may remove the inpatient part of the Maternity Care Plan. If this occurs the inpatient component will be moved from managed care and be FFS only.
3.13.012	The Vendor shall provide the capability to reject normal FFS claims for covered services rendered by capitated plans and processing of FFS claims not covered in the capitated plan.
3.13.013	The Vendor shall provide for the collection and generation of FFS data details (i.e., charges and fee schedule amounts) for capitated services as the result of the submittal and processing of encounter claims.
3.13.014	The Vendor shall provide through DSS the data for services rendered by providers who have contracted with managed care entities in order to determine the payments which Medicaid would have made for these services if they had been rendered on a fee for service basis.
3.13.015	The Vendor shall support the enrollment of recipients in one or more programs, including freedom of choice and/or automatic assignment waiver provisions.
3.13.016	The Vendor shall support the tracking of Maternity Care claims submitted for plan members who have exceeded stop-loss limits.
3.13.017	The Vendor shall make DSS data available to produce control reports identifying service outliers. The data shall include but not be limited to: age, sex, previous utilization and diagnosis.
3.13.018	The Vendor shall make DSS data available to report on recipient group utilization characteristics, including but not limited to types of services by program, eligibility category, and demographic characteristics (age, sex, place of residence, etc.)
3.13.019	The Vendor shall make DSS data available to report on Maternity Waiver Patient Profiles with the ability to produce query and ad-hoc reports.
3.13.020	The Vendor shall make DSS data available to report on program, provider, and recipient-specific service expense data, both historical and projected.
3.13.021	The Vendor shall provide the DSS data required to report on utilization expense analysis by member, per month
3.13.022	The Vendor shall provide the DSS data required to report on monthly enrollment and participation reports on new and multiple plans. These reports include but are not limited to program, provider, recipient, age, sex, aid category, etc.
3.13.023	The Vendor shall provide a method that will allow the Agency to generate new letters and modify current letters on-line real-time. The letters shall be printed and mailed by the Vendor within two (2) days of Agency entry.
3.13.024	The PHP program is currently in transition and is paid using the methodology in the Administrative Code – Chapter 23 in the Procurement Library. The program may be changed to FFS. If the program changes the methodology and the associated requirements will no longer be applicable. It will be a standard FFS program.
3.13.025	The Vendor shall ensure the PHP program covers all Medicaid eligible's, except those with

New #	Medical Services Requirements
	Medicare Part A. It covers only inpatient care for recipients in acute care facilities.
3.13.026	The Vendor shall provide a payment function for processing capitation claims, issuing monthly capitation payments and supporting remittance advices for the PHP plan which must report through the MMIS Financial functional area.
3.13.027	The Vendor shall provide for the collection and generation of FFS data details (e.g., charges and fee schedule amounts) for capitated services as the result of the submittal and processing of encounter claims. The information shall be produced monthly within five (5) days of the last check write of the month and sent to the PHP Vendor.
3.13.028	The Vendor shall provide historical data/costs on fee-for-service and encounter claims for use in calculating capitation rates.

3.14 Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Requirements

The Early and Periodic Screening, Diagnosis and Treatment (EPSDT) processing function serves as the Agency's mechanism to enroll, adjudicate, identify, and track EPSDT services, referrals and costs, and to generate EPSDT informing and screening letters to eligible recipients. All Medicaid fully eligible recipients, except Maternity Care and Plan First children under age 21 are eligible for EPSDT services. The Agency does not require Medicaid eligible children to be formally enrolled in the EPSDT program. The EPSDT processing function supports the state's goals of:

- providing medical assistance to recipients under the age of 21 with a continuing system of health screenings and treatment services to permit early detection of potentially chronic or disabling health conditions and referrals as medically necessary,
- encouraging regular health care for these recipients to reduce the occurrence of more serious and costly health problems, and
- maximizing federal funds for the provision of healthcare to eligible recipients under the age of 21

EPSDT-eligible children are allowed to receive services not always available to the general medical assistance population. EPSDT screening and treatment services are submitted on the CMS-1500, the UB-04, dental claim form, and managed care plan encounters using special state assigned procedure codes, modifiers, revenue codes or Current Dental Terminology (CDT) codes. The AMMIS should support the generation of EPSDT informing and screening letters to recipients. The primary objectives of the automated EPSDT function of the AMMIS are to:

- maintain identification of all individuals eligible for EPSDT services,

- provide paid claim records data to the state for EPSDT paid services,
- provide reports for tracking, validation, inquiry and monitoring purposes, and to meet federal and state reporting requirements (CMS 416).

The following are the requirements identified by the Agency that must be met by the Vendor to support the successful operation of the EPSDT related functions.

New #	EPSDT Requirements
3.14.001	The Vendor shall generate and mail EPSDT notices to patient's primary screening providers monthly for screening based on the State periodicity schedule no later than the 10th of the month preceding the month in which the screening is due. A copy of the report shall be stored in COLD and available to the Agency.
3.14.002	The Vendor shall generate and mail lists on a monthly basis informing providers of the need to provide immunizations to eligibles assigned to them under managed care or patient's primary physician in the fee for service (FFS) environment. The list shall be to the provider no later than the 10th of the month preceding the month in which the immunization is due. A copy of the report shall be stored in COLD and available to the Agency.
3.14.003	The Vendor shall produce monthly periodicity screening reports by the 10th of the month and quarterly referral service reports by the 10th of the month following the quarter's end. A copy of the report shall be stored in COLD and available to the Agency.
3.14.004	The Vendor shall generate and validate all federally mandated reports, as specified by the Agency. Currently, the CMS-416 is the only federally required report. The report shall be generated annually within three (3) days of the last checkwrite of the first calendar quarter (after the last checkwrite in March). The Vendor shall produce the report and the DSS supporting queries for the previous fiscal year ending September 30th. The report must meet the CMS-416 reporting requirements. A copy of the CMS-416 report shall be stored in COLD and available to the Agency.
3.14.005	The Vendor shall generate and validate the CMS-416 quarterly report and the DSS supporting queries by the 10th of the month following the end of the quarter. The quarterly report is used by the State to monitor the EPSDT program. The Vendor shall notify the State upon completion of report. A copy of the CMS-416 report shall be stored in COLD and available to the Agency.
3.14.006	The Vendor's system shall capture EPSDT medical, dental, hearing and vision screening data and services for EPSDT eligible's from fee for service data, health plan encounter data and/or a combination thereof for the formulation of the CMS-416 report.
3.14.007	The Vendor shall maintain on-line real time inquiry and search capability to EPSDT screening information including but not limited to: dates of Service, procedure codes, screening provider numbers, referral services, recipient ID, procedure codes, diagnosis codes, treatment dates for abnormal conditions and county code.
3.14.008	The Vendor shall audit all screening and immunization claims adjudicated (paid and denied) during claims processing. The claim data that relates to EPSDT includes but is not limited to: screening results and dates, referrals, treatment dates for abnormal conditions and immunization status. The Vendor shall maintain EPSDT data in the EPSDT system.
3.14.009	The Vendor's system shall process EPDST claims that are payable without a referral and

New #	EPSDT Requirements
	enforce the referral restriction for services that are only payable with an EPSDT referral.
3.14.010	The Vendor's system shall have the capability to track and report services provided both within the State Plan and outside the State plan.
3.14.011	The Vendor shall produce a file monthly of immunization data for Public health. The file must be to Public Health by the 10th of the month.
3.14.012	The Vendor shall provide an on-line user manual to instruct Agency staff on accessing EPSDT information. The Vendor shall maintain the on-line user manual to reflect current system functions. The Vendor shall provide hands-on user training for a minimum of twenty-four (24) Agency staff monthly or as requested by the Agency.

3.15 Management and Administrative Reporting (MAR) Requirements

The purpose of the Management and Administrative Reporting (MAR) function is to provide programmatic, financial, and statistical reports to assist the state and federal government with fiscal planning, control, monitoring, program and policy development, and evaluation of the State Medical Assistance Programs.

The MAR function is a comprehensive management tool which provides information on program status and trends, has the ability to analyze historical trends, and predicts the impact of policy changes on programs. This function uses key information from other AMMIS functions to generate standard reports.

The major inputs to MAR are data from all the claims processing functions as well as the financial, recipient, reference and provider areas. The major process is the generation of reports and program data, and the major outputs are the financial, statistical, and summary reports and data required by federal regulations, and other reports and data that assist the Agency in the management and administration of State Medical Assistance Programs.

The following are the requirements identified by the Agency that must be met by the Vendor to support the successful operation of the Management and Administrative Reporting related functions.

New #	MAR Requirements
3.15.001	The Vendor's Management Reporting Tool must compile and report data summarizing all services rendered under the Medicaid program requested by the Agency.
3.15.002	The Vendor shall provide reports based on Expenditures by Category of Service (COS). Selection criteria shall include but not be limited to, Benefit Plan, Aid Category, State COS, State Sub-COS, Fund Code, Unduplicated Recipient Count, and payment dates. The report shall have the capability to report by month, quarter, and fiscal year at the Agency's request. The report shall have the ability to compare reports with different selection criteria and shall include, but not be limited to, State Category of Service and description, Aid Category and description, Unduplicated Recipient Count, Units of Service, Paid Amount, and Average Paid

New #	MAR Requirements
	Amount per Recipient. This information shall be available on-line real-time.
3.15.003	The Vendor shall provide reports based on Payment by Category of Service (COS). Selection criteria shall include but not be limited to, Benefit Plan, Fund Code, Aid Category, State COS, State Sub-COS, Claim Type, Transaction Type, Unduplicated Recipient Count, and payment dates. The report shall have the capability to report by month, quarter, and fiscal year at the Agency's request. The report shall have the ability to compare reports with different selection criteria. The report shall include, but not be limited to, State Category of Service and description, Unduplicated Recipient Count, Number of Claims, Units of Service and Paid Amount for Paid Claims, Number of Claims and Billed Amount for Denied Claims. This information shall be available on-line real-time.
3.15.004	The Vendor shall provide reports based on Recipient Participation by Aid Category. Selection criteria shall include but not be limited to, Benefit Plan, Aid Category, State COS, State Sub-COS, Gender, Unduplicated Eligible's, County/Region, Age Group, Race, Unduplicated Recipients and payment dates. The report shall have the capability to report by month, quarter, and fiscal year at the Agency's request. The report shall have the ability to compare reports with different selection criteria. The report shall include, but not be limited to, Aid Category and description, Unduplicated Eligible's, Unduplicated Recipients, Percent Eligible Participation, Number of Claims Paid, Billed, Allowed, and Paid Amounts, Average Paid Amount per Eligible, and Average Paid Amount per Recipient. This information shall be available on-line real-time.
3.15.005	The Vendor shall provide reports based on Payment by Provider Type. Selection criteria shall include but not be limited to, Benefit Plan, Fund Code, Provider Type, Provider Specialty, Claim Type, Transaction Type, and payment dates. The report shall have the capability to report by month, quarter, and fiscal year at the Agency's request. The report shall have the ability to compare reports with different selection criteria. The report shall include, but not be limited to, Provider Type and Specialty and descriptions, Amount of Claims, Units of Service, and Paid Amount for Paid Claims, Amount of Claims and Billed Amount for Denied Claims. This information shall be available on-line real-time.
3.15.006	The Vendor shall provide reports based on Participation by Category of Service (COS). Selection criteria shall include but not be limited to, Benefit Plan, Aid Category, State COS, State Sub-COS, Gender, Unduplicated Recipient Count, County/Region, Age Group, Race, and payment dates. The report shall have the capability to report by month, quarter, and fiscal year at the Agency's request. The report shall have the ability to compare reports with different selection criteria. The report shall include, but not be limited to, State Category of Service, Unduplicated Recipient Count, Percent Eligible Participation, Number of Claims Paid, Billed, Allowed, and Paid Amount and Average Paid Amount per Recipient. This information shall be available on-line real-time.
3.15.007	The Vendor shall provide reports based on Place of Service Analysis. Selection criteria shall include but not be limited to, Benefit Plan, Fund Code, State COS, State Sub-COS, Unduplicated Recipient Count, County/Region, Age Group, and payment dates. The report shall have the capability to report by month, quarter, and fiscal year at the Agency's request. The report shall have the ability to compare reports with different selection criteria. The report shall include, but not be limited to, Place of Service and description, Unduplicated Recipient Count, Number of Claims Paid, Paid Amount, Average Paid Amount per Claim, and Average Paid Amount per Recipient. This information shall be available on-line real-time.

New #	MAR Requirements
3.15.008	The Vendor shall provide reports based on Long Term Care by Revenue. Selection criteria shall include but not be limited to, Benefit Plan, Fund Code, Aid Category, Provider Number, Level of Care, payment dates, and Unduplicated Recipient Count. The report shall have the capability to report by month, quarter, and fiscal year at the Agency's request. The report shall have the ability to compare reports with different selection criteria. The report shall include, but not be limited to, Average Paid Amount per Patient Day, Average Paid Amount per Provider, Average Applied Income per Patient Day, Average Paid Amount per Recipient, Total Number of Providers, Allowed Amount, Other Insurance Amount, Patient Liability Amount, Paid Amount, Revenue Codes, Unduplicated Recipient counts, Number of Days of Care and Billed Amount. This information shall be available on-line real-time.
3.15.009	The Vendor shall provide reports based on Error Code Analysis. Selection criteria shall include but not be limited to, Benefit Plan, Fund Code, Provider Type, Provider Specialty, Code Type, County/Region, Provider Number, Payment Dates, and Provider Detail. The report shall have the capability to report by month, quarter, and fiscal year at the Agency's request. The reports shall have the ability to compare reports with different selection criteria. The report shall include, but not be limited to, Error Code and description, the number of Error Claims, Unduplicated Provider Number, number of Provider Claims and a Percent of all Claims filed. This information shall be available on-line real-time.
3.15.010	The Vendor shall provide reports based on Operational Performance by Provider. The selection criteria including, but not limited to, Benefit Plan, Provider Type, Provider Specialty, Fund Code, and payment dates. The report shall have the capability to report by month, quarter, and fiscal year at the Agency's request. The report shall have the ability to compare reports with different selection criteria. The report shall include, but not be limited to, Provider Type and Provider Specialty with descriptions, the number of Claims Processed, Claims Paid, Claims Denied, Claims Pending, Adjusted Claims Paid, Adjusted Claims Denied and the total Pending Billed Amount. This information shall be available on-line real-time.
3.15.011	The Vendor shall provide reports based on Thru put Analysis Date of Receipt (DOR) to Date of Adjudication (DOA). Selection criteria shall include but not be limited to, Benefit Plan, Fund Code, Provider Type, Provider Specialty, ICN Region, and payment dates. The report shall have the capability to report by month, quarter, and fiscal year at the Agency's request. The report shall have the ability to compare reports with different selection criteria. The report shall include, but not be limited to, Provider Type and Provider Specialty with descriptions, the total number of Claims Received, then number and percent of claims that have 2, 4, 7, 14, 21, 30, 60, and over 60 days from DOR to DOA, and the Average Number of Days to Adjudicate. This information shall be available on-line real-time.
3.15.012	The Vendor shall provide reports based on Operational Performance Averages and Percentages. Selection criteria including, but not be limited to, Benefit Plan, Provider Type, Provider Specialty, Fund Code, and Payment Dates. The report shall have the capability to report by month, quarter, and fiscal year at the state's request. The report shall have the ability to compare reports with different selection criteria shall include but not be limited to provider type and specialty and descriptions, paid claim amount, paid claim amount for this month, same month last year, SFYTD this year, and last year. This information shall be available on-line real-time.

New #	MAR Requirements
3.15.013	The Vendor shall provide reports based on Provider Error Analysis. Selection criteria shall include but not be limited to, Benefit Plan, Provider Type, Provider Specialty, Provider Number, County/Region, and Payment Dates. The report shall have the capability to report by month, quarter, and fiscal year at the Agency's request. The report shall have the ability to compare reports with different selection criteria. The report shall include, but not be limited to, Total Claims, Claims Paid and Denied, Total Corrected Claims, Total Claims Paid After Corrected, Percent Paid with No Error, Percent with Error Override, Percent Denied, and the Average Error per Adjudicated Claim for both Individual Providers and Provider Peer Groups. This information shall be available on-line real-time.
3.15.014	The Vendor shall provide reports based on Thru put Analysis Date of Receipt (DOR) to Date of Payment (DOP). Selection criteria shall include but not be limited to, Benefit Plan, Fund Code, Provider Type, Provider Specialty, ICN Region, and Payment Dates. The report shall have the capability to report by month, quarter, and fiscal year at the Agency's request. The report shall have the ability to compare reports with different selection criteria. The report shall include, but not be limited to, Provider Type and Provider Specialty with descriptions, the total number of Claims Received, then number and percent of claims that have 7, 14, 21, 30, 60, 90 and over 90 days from DOR to DOP, and the Average Number of Days to Pay the claim. This information shall be available on-line real-time.
3.15.015	The Vendor shall provide reports based on Operational Performance Dollars. Selection criteria shall include but not be limited to, Benefit Plan, Provider Type, Provider Specialty, Fund Code, and Payment Dates. The report shall have the capability to report by month, quarter, and fiscal year at the Agency's request. The report shall have the ability to compare reports with different selection criteria. The report shall include, but not be limited to, Provider Type and Provider Specialty with descriptions, the Billed Amount for Paid Claims, Denied Claims, and Pending Claims, Total Charges Submitted, and the Billed Amount minus the Paid Amount. This information shall be available on-line real-time.
3.15.016	The Vendor shall provide reports based on Provider Filing Analysis. Selection criteria shall include but not be limited to, Benefit Plan, Fund Code, Provider Type, Provider Specialty, County/Region, Provider Number, and Payment Dates. The report shall have the capability to report by month, quarter, and fiscal year at the Agency's request. The report shall have the ability to compare reports with different selection criteria. The report shall include, but not be limited to, Average (Date of Service) DOS to DOR, Average DOR to DOP, and Average DOS to DOP for both Individual Providers and Provider Peer Groups. Report shall also give a summary of the Number of Claims and the Percent of Total Claims by the number of DOS to DOR days for the following groupings: 1-7, 8-14, 15-30, 31-60, 61-90, and more than 90 for both Individual Providers and Provider Peer Groups. This information shall be available on-line real-time.
3.15.017	The Vendor shall provide reports based on Provider Payment Comparison by COS. Selection criteria shall include but not be limited to, Benefit Plan, Fund Code, State COS, County/Region, Report Period, and State Sub-COS. The report shall have the capability to report by month. Have the ability to compare reports with different selection criteria. The report shall include, but not be limited to, State COS and description, paid claim count and paid amount for this month, for the same month last year, SFYTD this year and last year. This information shall be available on-line real-time.

New #	MAR Requirements
3.15.018	The Vendor shall provide reports based on Provider Participation Total. Selection criteria shall include but not be limited to, Benefit Plan, Provider Type, Provider Specialty, Unduplicated Recipients, County/Region, State COS, State Sub-COS, and Payment Dates. The report shall have the capability to report by month, quarter, and fiscal year at the Agency's request. The report shall have the ability to compare reports with different selection criteria. The report shall include, but not be limited to, Provider Type and Provider Specialty and descriptions, the number of Providers Enrolled, and Participate, and the Participation Percentage, Unduplicated Recipient Count, Amounts for Claims Paid, Claims Denied, and Total Paid. This information shall be available on-line real-time.
3.15.019	The Vendor shall provide reports based on Payment Comparisons by Provider Type. Selection criteria shall include but not be limited to, Benefit Plan, Provider Type, Provider Specialty, Fund Code, County/Region, and Payment Dates. The report shall have the capability to report by month, quarter, and fiscal year at the state's request. The report shall have the ability to compare reports with different selection criteria. The report shall include, but not be limited to, provider type and specialty and description, paid claim count and paid amount for this month, same month last year and SFYTD this year and last year. This information shall be available on-line real-time.
3.15.020	The Vendor shall provide reports based on Provider Rankings. Selection criteria shall include but not be limited to, Benefit Plan, Fund Code, Provider Type, Provider Specialty, Sort, Unduplicated Recipients/Average Paid Amount, County/Region, Claim Type, Provider Number, and Payment Dates. The report shall have the capability to report by month, quarter, and fiscal year at the Agency's request. The report shall have the ability to compare reports with different selection criteria. The report shall include, but not be limited to, Provider Number, Provider Name, Number of Claims Paid and Denied, Paid Amount, Billed Amount for Paid Claims and Denied Claims, Average Paid Amount, Percent Paid and Billed, Average Paid Amount per Recipient, and Ranking. This information shall be available on-line real-time.
3.15.021	The Vendor shall provide reports based on Provider Participation Average. Selection criteria shall include but not be limited to, Benefit Plan, Provider Type, Provider Specialty, County/Region, State COS, State Sub-COS, and Payment Dates. The report shall have the capability to report by month, quarter, and fiscal year at the Agency's request. The report shall have the ability to compare reports with different selection criteria. The report shall include, but not be limited to, Provider Type and Provider Specialty and descriptions, Recipients per Provider, Paid and Denied Claims per Provider, Paid Amount per Provider, Paid Amount per Recipient, Billed Amount per Paid and Denied Claims. This information shall be available on-line real-time.
3.15.022	The Vendor shall provide reports based on Third Party Payment Ranking. Selection criteria shall include but not be limited to, Benefit Plan, Fund Code, Provider Type, Provider Specialty, Claim Type, County/Region, and Payment Dates. The report shall have the capability to report by month, quarter, and fiscal year at the Agency's request. The report shall have the ability to compare reports with different selection criteria. The report shall include, but not be limited to, Provider Number, Provider Name, number of Claims Paid, number of TPL Claims Paid, TPL Percentage of all Claims Paid, Total Billed Amount, TPL Dollars, TPL Dollars Percentage of Billed Amount, and Ranking of TPL to Paid. This information shall be available on-line real-time.

New #	MAR Requirements
3.15.023	The Vendor shall provide reports based on Medicare Participation Part A. Selection criteria shall include but not be limited to, Benefit Plan, Fund Code, State COS, State Sub-COS, Aid Category, Unduplicated Eligible's, and Payment Dates. Report shall have the capability to report by month, quarter, and fiscal year at the Agency's request. The report shall have the ability to compare reports with different selection criteria. The report shall include, but not be limited to, Aid Category and description, number of Eligible's, Claims Paid, Medicaid Allowed and Paid Amount, Medicare Paid Amount, Percent of Total Paid Amount, Buy-in Premium and Percent Buy-in of Medicare Paid Amount. This information shall be available on-line real-time.
3.15.024	The Vendor shall provide reports based on Medicare Participation Part A and B. Selection criteria shall include but not be limited to, Benefit Plan, Fund Code, Aid Category, Unduplicated Eligible's, and Payment Dates. The report shall have the capability to report by month, quarter, and fiscal year at the Agency's request. The report shall have the ability to compare reports with different selection criteria. The report shall include, but not be limited to, Total Eligible's with Part A and B, Total Medicaid/Medicare Eligible's, Total Medicaid Paid Amounts, Total Medicare Paid Amounts, Total Medicare and Medicaid Paid Amounts, Percent of Medicaid Payments. This information shall be available on-line real-time.
3.15.025	The Vendor shall provide reports based on Medicare Participation Part B. Selection criteria shall include but not be limited to, Benefit Plan, Fund Code, State COS, State Sub-COS, Aid Category, Unduplicated Eligible's, and Payment Dates. The report shall have the capability to report by month, quarter, and fiscal year at the Agency's request. The report shall have the ability to compare reports with different selection criteria. The report shall include, but not be limited to, Aid Category, Unduplicated Eligible's, Claims Paid, Medicaid Allowed Amount, Medicaid Paid Amount, Medicare Paid Amount, Percent Paid of Total Paid (by Medicare), Buy-in Premium and Percent Buy-in of Medicare Paid Amount . This information shall be available on-line real-time.
3.15.026	The Vendor shall provide reports based on Recipient Co-pay. Selection criteria shall include but not be limited to, Benefit Plan, Fund Code, Aid Category, Co-payment Type, and Payment Dates. Report shall have the capability to report by month, quarter, and fiscal year at the Agency's request. The report shall have the ability to compare reports with different selection criteria. The report shall include, but not be limited to, Aid Category, Paid Claims with Co-pays, Total Claims Paid, Percent Claims Co-pay, Co-pay Deducted, Billed, Allowed, and Paid Amount. This information shall be available on-line real-time.
3.15.027	The Vendor shall provide reports based on Recipient Participation By County. Selection criteria shall include but not be limited to, Benefit Plan, Fund Code, Aid Category, Claim Type, State COS, State Sub-COS, County/Region, Age Group, Gender, Race, and Payment Dates. The report shall have the capability to report by month, quarter, and fiscal year at the Agency's request. The report shall have the ability to compare reports with different selection criteria. The report shall include, but not be limited to, Recipient County, Unduplicated Eligible's, Unduplicated Recipients, Percent of Eligible Participation, Paid Amount, Average Paid Amount per Eligible, Average Paid Per Recipient. This information shall be available on-line real-time.

New #	MAR Requirements
3.15.028	The Vendor shall provide reports based on Recipient Ranking. Selection criteria shall include but not be limited to, Benefit Plan, Fund Code, Aid Category, County/Region, Claim Type, and Payment Dates. Report shall have the capability to report by month, quarter, and fiscal year at the Agency's request. The report shall have the ability to compare reports with different selection criteria. The report shall include, but not be limited to, Recipient Current ID, Claims Paid and Denied, Paid Amount, Billed Amount for Paid and Denied Claims, Average Paid Amount, Percent Paid, Percent Billed, and Ranking. This information shall be available on-line real-time.
3.15.029	The Vendor shall provide reports based on Sterilizations. The report shall include, but not be limited to, Recipient ID, ICN, Provider Number, Procedure Code, Modifier, Primary Diagnosis, Secondary Diagnosis, Claim Type, Fund Code, Place of Service (POS), Category of Service (COS), Service Units, Age, Sex, Service Date, Payment Date, Amount Billed and Paid. Totals shall be summed by claim type (Professional, Outpatient, Inpatient, and Total). Report shall have the capability to report by month and year. This report shall be produced monthly and stored in COLD.
3.15.030	The Vendor shall provide reports based on Abortions. The report shall include, but not be limited to, Recipient ID, ICN, Provider Number, Procedure Code, Modifier, Primary Diagnosis, Secondary Diagnosis, Claim Type, Fund Code, Place of Service (POS), Category of Service (COS), Service Units, Age, Sex, Service Date, Payment Date, Amount Billed and Paid. Totals shall be summed by claim type (Professional, Outpatient, Inpatient, and Total). Report shall have the capability to report by month and year. This report shall be produced monthly and stored in COLD.
3.15.031	The Vendor shall provide Month End Claims Processing Analysis. This report shall be produced monthly and stored in COLD.
3.15.032	The Vendor shall provide Monthly Reconciliation. The Vendor shall provide written documentation on the MAR reconciliation process that the vendor will use to reconcile the Medicaid monies and counts in MAR to the reports used as input to the CMS-64 and the monthly Claims Payment Processing Information (the Approved to Pay Summary report). The information used in the process must be delivered to the Agency by the end of the week following the last checkwrite of the month.
3.15.033	The Vendor shall generate, submit and correct MSIS files for CMS, according to CMS' timeframes and format. The files are created quarterly and must be to the Agency by the end of the month following quarter end.
3.15.034	The Vendor shall document reasons for CMS identified errors on MSIS file validation and correct errors as approved by the Agency within twenty (20) days of identification of the errors.
3.15.035	The Vendor shall update MAR data after each check write. The MAR data must contain the necessary data elements to produce reports and analyses defined as requirements in this section. This data must be available the first working day after checkwrite processing. The data shall include but is not limited to: • Adjudicated, suspended, and encounter claims data, adjustments and financial transactions, for the reporting period, from the Claims Reporting function and the Managed Care function. • Reference data, for the reporting period. • Provider data, for the reporting period.

New #	MAR Requirements
	• Recipient data, for the reporting period, from the Recipient Data, LTC, EPSDT, and TPL functions. • Health Insurance Premium Payments (HIPP) indicator and Parts A and B Buy-In information for the reporting period (including Buy-in premiums).
3.15.036	The Vendor shall ensure the accuracy of all reports prior to the first production run.
3.15.037	The Vendor shall provide and maintain complete user documentation for reporting systems which define the purpose of each report, specifically describes the definition of each reporting category and data elements contained therein, their sources, the calculations involved in their determination, balancing instructions, the frequency of the report and the report distribution and media. Includes a master matrix of data elements indicating which reports contain a particular data element. This information must be updated when any changes are made to the MAR system.
3.15.038	The Vendor shall provide training for the management reporting functions to new Agency staff, anytime major changes are made to the MAR system or up to twice a year at the request of the Agency.
3.15.039	The Vendor shall generate reports using data contained in the Management Reporting system that is not available by on-line request or in COLD in either on-line, hard copy, CD-ROM or DVD format as requested by the agency within two (2) days.
3.15.040	The Vendor shall respond to any issue in five (5) days with the details of the problem and identify any corrections (if required). The required corrections, validations, report rerun (if required), and management report distribution (if required) shall occur within three (3) days of Agency approval of the response.
3.15.041	The Vendor shall provide data for CMS reports on annual basis or as requested by the Agency. If requested by the Agency, reports shall be delivered within one (1) week of request.
3.15.042	The Vendor shall provide a report of waiver and special program participation and expenditure data, including services, payments, billed amounts, units, eligible's, unduplicated recipient counts and total cost of care by date of service. The report shall be produced annually within five (5) days of the Agency request. This requirement specifically meets the need for CMS-372 reporting requirements.
3.15.043	The Vendor shall ensure the Management Reporting Tool has the ability to house at least five (5) years of data and reports.
3.15.044	The Vendor shall maintain the information in the MAR system to reflect the current MMIS. This shall include but not be limited to: changes or additions to categories of service, recipient aid categories, provider types and specialties, benefit plans, state categories of service, and fund codes.
3.15.045	The Vendor shall maintain the Agency approved MAR documentation to reflect the current status of MAR. The documentation or users manual must be updated prior to implementing any changes into the MAR system.
3.15.046	The Vendor shall provide multiple output media capabilities, including vendor printing, on-line real-time report viewing and batch report viewing to support MAR. MAR shall allow all

New #	MAR Requirements
	reports to be saved in multiple formats including but not limited to text and MS EXCEL.

3.16 Surveillance and Utilization Review (SUR) Requirements

The Surveillance and Utilization Review (SUR) function provides the capability to identify, report, and support the investigation of potential fraud and/or abuse of the Medicaid program by providers and recipients. The modular design of the solution enables detection components to accept data directly from the AMMIS Decision Support System (DSS). The SUR components are:

Case Tracking

The Case Tracking application replaces many of the manual operations throughout the SUR case review process with systematic approaches. Browser-based windows allow for auto-assignment of case reviews and online updating of case documentation. In addition, the Case Tracking application facilitates the viewing of incoming imaged correspondence and photocopied medical records from on-site audits. The application provides for the storage of report and spreadsheet files generated within the AMMIS and DSS areas and can link the files to related SUR cases. All case documentation, including imaged documentation, is linked to a SUR case utilizing a unique identifier called a Master Log Number. Each SUR case has an associated electronic SUR case file, which helps in identifying the steps the SUR analyst followed while researching the SUR case.

Episode treatment Grouper (ETG)

The ETG grouper integrated in the SUR will allow measuring the effect of health care services on cost and quality. The ETG solution does this by identifying episodes of care, which encompass all health care services provided to an individual patient during a single illness. An episode of care is defined as all clinically related services for a discrete diagnostic condition from the onset of symptoms until treatment is complete. Episodes of care provide a clinically meaningful unit of analysis for measuring both the cost and quality of patient care.

Random Sample Generator

The data warehouse also provides the ability to generate summary reports from a statistically valid random sampling process. The random sample process is initiated and accessed through browser-based windows from the data warehouse Web site. Through this Web site, users can specify if they want to sample claims for providers or members, and they can specify the date ranges and other filter conditions such as specific claim types or code values. The results from the sample are stored in the data warehouse where the results can be reported on summary Web screens or from reports generated through the data warehouse.

These components are accessed through the DSSNavigator. The Data Warehouse is populated

with data from the AMMIS, which allows the Data Warehouse to source data to the Random Sample application, Targeted Queries and the DSSProfiler process. Having everything contained within the Data Warehouse helps to ensure that all of the data used to identify a suspect list comes from the same source and speeds verification.

DSS Profiler

The DSSProfiler is an integrated query, reporting, and analysis tool that uses information from the DSS Database and currently is the primary source of day to day operations of the SUR Program Areas.

The DSS Database is pulled from the AMMIS. DSSProfiler pulls 12 months of paid claims from the AMMIS based on first date of service. The DSSProfiler reports on the entire 12 months of claims (Yearly Process) and also reports by a single quarter of claims from within the 12 months. The Profiler enables comparisons of expected and paid amounts among a specific Provider or Recipient peer group and between a specific Provider or Recipient and their peer group.

The following are the requirements identified by the Agency that must be met by the Vendor to support the successful operation of the Surveillance and Utilization Review related functions.

New #	SUR Requirements
3.16.001	The Vendor shall respond to any issue related to the SUR system within one (1) day of the issue being discovered or notified by the Agency. The response shall be a temporary work-around, a resolution to the issue, or a plan of action. Work-around or a plan of action shall be resolved to the Agency's approval within thirty (30) calendar days of opening the issue.
3.16.002	The Vendor shall designate a SURS Analyst to support SUR Recipient, SUR Provider and SUR Pharmacy. The SURS Analyst shall have a minimum of two (2) years experience with utilization reviews. This support shall include but not be limited to on-site support at the request of the Agency, training, user manual updates, net meeting or webinar, telephone and e-mail support. The SURS Analyst shall respond to all issues, telephone or e-mail inquires within one (1) day with the answer to the question or a suggested temporary work-around (maximum of thirty (30) days for work-around) for a problem. The SURS Analyst must be at the Vendor's Montgomery AL facility and available to support the Agency within thirty (30) days of contract signing. The SURS Analyst shall be available to support testing of enhancements and any transitional task.
3.16.003	The Vendor's SUR system shall report on encounter claims and amounts as well as FFS claims. The Vendor shall ensure that paid amount for Encounter claims are at a header level and that FFS are paid at a detail level.
3.16.004	The Vendor shall maintain the SUR functionality that utilizes adjudicated claims data, encounter data and enrollment data; that has the capability to provide summary and individual data; and performs exception processing.
3.16.005	The Vendor shall ensure that the analysis of any issue (change order or defect) identifies the impact to SUR and initiate a change order to modify SUR if applicable. The Vendor shall produce and document testing to ensure the change is correct and there are no negative impacts to the current system. The test results must be sent to the Agency or presented in person as requested by the Agency to obtain approval.

New #	SUR Requirements
3.16.006	The Vendor's SUR system shall allow documents and correspondence to be uploaded and attached to a case using the case tracking function of the system.
3.16.007	The Vendor shall produce Management summary reports, by case type and peer group, to include such areas as: Case Types/Peer Group Field Totals; Frequency Distributions; Exception Report Item Totals (including norms, class group reports, exception limits, and number of exceptions); Profile reports; Recipient Exception Profiles; Provider Exception Profiles; Recipient Summary Profiles; Provider Summary Profiles.
3.16.008	The Vendor shall allow unlimited peer groups and case types for providers and recipients.
3.16.009	The Vendor shall produce ambulatory and inpatient services provided to nursing facility residents within a single report by long-term care facility (long-term care wraparound reporting) to include LTC and inpatient and outpatient hospital claims.
3.16.010	The Vendor shall allow provider and recipient reports to select FFS (Fee For Service) claims, Encounter claims, or both.
3.16.011	The Vendor shall provide on-line reports to compare provider and recipients by case type and/or peer group to identify over and under utilization of services including but not limited to: Managed Care, dental, medical, prescribing, laboratory, supply and durable medical services.
3.16.012	The Vendor shall provide an on-line detail analysis report of individual provider or recipient information to identify the over and under utilization of services including but not limited to: medical, dental, prescribing, laboratory, supply and durable medical services.
3.16.013	The Vendor shall provide on-line summary and detail information on hospital stays by such areas as recipient, diagnosis and provider classification, including length of stay, room and board charges, ancillary charges and medical expenses prior to and immediately following the hospital stay in comparison to the associated rate that was used for payment.
3.16.014	The Vendor shall provide an on-line report selection criterion that will enable the Agency to report on provider or recipient services received, drugs, programs or specialties.
3.16.015	The Vendor shall provide an on-line reporting function with features including but not limited to; selective provider or recipient information, summary data, profile data and ranking of exceptions.
3.16.016	The Vendor's SUR system shall have the ability to produce reports in any of the following formats: - paper - PDF - electronic The Vendor shall provide the capability to store reports in COLD or Infoview and to export report data to MS Office products such as EXCEL or WORD.
3.16.017	The Vendor shall provide a detail report for all claim types for a specified provider or recipient for a specified date range. The section criteria shall be NPI, Medicaid ID, Base ID or recipient ID. The claim detail report shall include but not be limited to summary of procedures codes, diagnosis codes, place of service, Provider name & ID, Recipients name & ID, Medicaid paid & allowed amount and ICN's.

New #	SUR Requirements
3.16.018	The Vendor's SUR system shall display all codes and code descriptions on reports including but not limited to: procedure codes, procedure code modifiers, diagnosis codes, revenue codes, NDC's, benefit plan codes, taxonomy codes, and other codes identified by the Agency.
3.16.019	The Vendor staff shall notify the Agency Surveillance & Utilization Review Unit of any identified or suspected instances of potential fraud or abuse within one (1) day of discovery.
3.16.020	The Vendor shall maintain a current user manual for the SURS system. The manual updates shall be presented as part of test review and will require Agency approval before moving to production.
3.16.021	The Vendor shall provide hands-on training to the Agency staff on features and reports. Formal training shall be provided within one (1) month of request. This training shall include hand-outs and hands-on exercises. The follow-up training shall be provided within two (2) weeks of request and shall be small groups with step by step instructions on a specific topic identified by the Agency.
3.16.022	The Vendor shall maintain a current and complete SURS documentation library and update as needed or when modifications are made to the SURS functions and/or features. The changes shall be presented with test results and approved by the Agency before moving to production.
3.16.023	The Vendor shall use data from other subsystems, including claims history, provider demographic and enrollment data, recipient demographic and eligibility data, reference data and service or drug codes, LTC data, diagnosis codes and any other data required to support SURS reporting. At a minimum, the SUR system shall have the most current twelve (12) months of data with a three (3) month lag and will be updated quarterly and as directed by the Agency.
3.16.024	The Vendor's SUR System shall have web-like panels with drop-downs and GUI (Graphical User Interface) type features.
3.16.025	The Vendor shall provide panels that allow the Agency to specify the control criteria used for the SUR profiling process. This criteria includes but is not limited to case types, case categories and case groups. This control criteria will be used to select the DSS data that will be pulled into the SUR system.
3.16.026	The Vendor shall generate yearly and quarterly statistical profiles (by running the SUR Profiler), for providers, recipients and pharmacy, summarizing information on claims and encounter history submitted by each provider or health plan. The SUR system will maintain four (4) quarters of data with a one (1) quarter lag. The Vendor shall run the SUR profiler the first weekend of each quarter that is not a checkwrite weekend or at the request of the Agency.
3.16.027	The Vendor shall generate statistical norms (using the SUR profiler), by case type and/or peer groups for each functional area within each statistical profile by using averages, standard deviations, percentiles or absolute values. The profiler shall use this information to define the norms to set the exception limits.
3.16.028	The Vendor's SUR Profiler shall evaluate the statistical profiles of all individual providers or recipients within each case group and/or peer group against the matching exception criteria established for each case group and/or peer group.

New #	SUR Requirements
3.16.029	The Vendor's SUR Profiler shall Identify providers and recipients who exhibit aberrant practice or utilization patterns, (both under- and over-utilization) as determined by an exception process, comparing the individuals' profile to the limits established for their respective peer groups.
3.16.030	The Vendor's SUR Profiler shall generate lists of providers and recipients who are found to be exceptional, ranked in order of severity.
3.16.031	The Vendor's SUR Profiler shall maintain profiles for inpatient, outpatient, Nursing Facility, Recipient, Pharmacy, Provider, Professional and Professional Referral.
3.16.032	The Vendor's SUR Profiler shall provide on-line search/reporting. The search/reporting shall include but not be limited to case type comparisons, exception reports, peer group comparisons, frequency distributions, distribution analysis, provider profile (provider summary), recipient profile (recipient summary), ETG (Episode Treatment Grouper), disease reporting, targeted queries and detail reports for each.
3.16.033	The Vendor shall classify recipients into peer groups using criteria including but not limited to living arrangement (head of household/payee number), geographic region, aid category, recipient payee number, participation in fee-for-service vs. managed care, agency origin, and special programs (special programs are assigned an aid category) for the purpose of developing statistical profiles.
3.16.034	The Vendor's SUR Profiler shall link all services to a single recipient regardless of the number of historical changes in recipient ID.
3.16.035	The Vendor's SUR Profiler shall maintain the ability to profile all services provided to a recipient during a single episode of care. This is currently accomplished using the ETG software.
3.16.036	The Vendor shall provide on-line selection to classify providers into peer groups using criteria including but not limited to provider specialty, sub-specialty, billing vs. rendering provider, participation in fee-for-service vs. managed care, and geographic region. The Vendor shall provide ability to define class group based on multiple criteria (e.g., provider type and geographic area) for the purpose of developing statistical profiles.
3.16.037	The Vendor's SUR Profiler shall associate individual providers in their group or clinic practice.
3.16.038	The Vendor shall maintain a methodology to classify treatment into peer groups, by diagnosis or range of diagnosis codes, for the purpose of developing statistical profiles.
3.16.039	The Vendor's SUR Profiler shall maintain the capability to distinguish between services rendered by a provider or practitioner as part of group or managed care plan, versus services rendered by the same provider in their individual practice. Also maintain the ability to profile the group or managed care plan as a distinct entity. The Profiler shall track managed care practitioners who belong to multiple managed care plans.
3.16.040	The Vendor's SUR Profiler shall provide the capability to class group managed care programs by provider peer groups.
3.16.041	The Vendor's SUR Profiler shall support managed care exception reporting by identifying providers that are paid capitation payments with below or above normal office visits.

New #	SUR Requirements
3.16.042	The Vendor shall provide the data needed to report on referral processing services ordered by a physician or case manager from inpatient and outpatient hospital, pharmacy, independent labs and physician claims into the referring provider's profiles.
3.16.043	The Vendor's SUR Profiler shall provide the capability to identify a billing provider that is repeatedly using the same referring provider number.
3.16.044	The Vendor's SUR Profiler shall provide the capability to identify a billing provider that is repeatedly using his/her number as the referring provider number (self referral).
3.16.045	The Vendor's SUR Profiler shall have the capability to suppress class groups, providers or recipients from exception report printing and ranking (filters).
3.16.046	The Vendor shall produce comparative reports of benefit plan utilization summaries with Medicaid-only data.
3.16.047	The Vendor shall maintain the capability to generate treatment analysis reports (targeted queries) based on user-defined parameters.
3.16.048	The Vendor shall maintain a process to select and print claims and encounter data at the request of the user, in such a way that all information that is of value in making a determination of mis-utilization is displayed for the user.
3.16.049	The Vendor shall generate frequency distributions and print at the Agency's request.
3.16.050	The Vendor's SUR system shall apply rankings to exception report items to facilitate the identity of the highest deviations.
3.16.051	The Vendor shall perform analysis of rendering, referring and billing practices to detect utilization and/or billing problems, such as incidental or mutually exclusive procedures, unbundling of procedure codes, bill splitting, overprescribing, unnecessary referring, etc. and separately identify these according to the rendering provider, referring provider and/or the billing provider.
3.16.052	The Vendor's SUR Profiler shall maintain the ability to suppress deceased recipients from exception reports (filters).
3.16.053	The Vendor's SUR Profiler shall produce comparative reports of encounter data indicators (including comparisons with FFS claims).
3.16.054	The Vendor shall maintain a test environment that gives the Agency the capability to develop, design, modify and test alternative report parameters and maintain an indexed library of such report parameters.
3.16.055	The Vendor shall maintain the capability to take an electronic extract of claims detail from SURS and put it into a spreadsheet which can be manipulated and sent to providers.
3.16.056	The Vendor shall have narrative descriptions of procedures, drugs and diagnoses on **all** reports.
3.16.057	At the request of the Agency, the Vendor shall schedule reports to run on a predefined schedule. A scheduled report shall be printed and delivered to the Agency the next business day after the run completes.

3.17 Decision Support System (DSS) Requirements

The Data Warehouse subsystem otherwise known as DSS provides access to the AMMIS data and various external data sources. The data is stored in an Oracle RDBMS and is accessed through the BusinessObjects application. Within BusinessObjects, universes will be created by functional area. The universes are the data-models that show the relationships among the individual elements. The universes remove the technical knowledge needed to develop and run queries in the system. Data elements are given practical names and logically grouped for easy location and selection. The users will simply use common Windows-like features such as drag and drop to quickly develop queries.

Through DSS, users of all experience levels can generate reports that range from simple queries to more complex reporting and data analysis. By facilitating data analysis and reporting, DSS will help to better manage and maintain the AMMIS system and the Agency's Medicaid program as a whole.

DSS combines specialized tools and processes to make enterprise data easily accessible for ad hoc query and reporting or for producing regularly scheduled reports. Capitation, encounter, fee for service claims and other AMMIS data are included in DSS and can be combined and formatted into reports by both novice and power users.

DSS is comprised of programs and processes to extract data from the AMMIS and store it in an Oracle database accessed by BusinessObjects. The following tools and functionality are included in DSS:

- High performance data storage and access using Oracle with partitioning option;
- Pre-built BusinessObjects Universes that provide a completely documented semantic layer allowing non-technical users to understand the data and build complex optimized queries to access it;
- Pre-built BusinessObjects Reports which are predefined queries that are stored in a formatted report within the BusinessObjects Repository; and
- The BusinessObjects tool suite for reporting, environment control, and monitoring, consisting of these components:
    - Reporter to build queries and format advanced reports and graphs.
    - Designer to build universes that document the data and define how it is accessed.
    - Supervisor to define various levels of users and the data, reports, and functions to which they have access.
    - Scheduler to automate the running of periodic reports and large long running reports at off-peak times.

- InfoView to provide a web based common access point and report library to system components and pre-built reports.

The following are the requirements identified by the Agency that must be met by the Vendor to support the successful operation of the Decision Support System related functions.

New #	DSS Requirements
3.17.001	The Vendor shall ensure the DSS claim, financial and MAR data shall be updated after each checkwrite and the data must be available the first day after completion of the checkwrite processing.
3.17.002	The Vendor shall ensure that DSS defines and populates **all elements** from claims, claims history, all financial transactions and reference. This shall include but not be limited to refunds, adjustments, re-keys, voids, payouts, buy-in premiums and HIPP payments.
3.17.003	The Vendor shall ensure the TPL, recipient, provider, prior authorization and reference data is updated weekly and the data must be available the first day of the week.
3.17.004	The Vendor's DSS shall have modeling and forecasting features that provide the user with the flexibility to identify and test assumptions about the Medicaid program (particularly with regard to budget management, cost containment, utilization management, program operations and access to care).
3.17.005	The Vendor's DSS shall continue to allow Medicaid to take full advantage of the breadth and depth of Medicaid/managed care data captured on the MMIS to more effectively manage the complexity and scope of the Agency fee for service (FFS) and managed care programs and to aggressively contain costs while ensuring access to medically necessary, quality health care.
3.17.006	The Vendor's DSS shall provide program management, financial analysis and ad hoc reporting, audit support, and analysis and reporting of access, quality, use and cost of fee for service care and managed care incorporating encounter as well as fee for service data.
3.17.007	The Vendor's DSS shall provide multiple output media capabilities, including Vendor printing, on-line real-time report viewing and batch report viewing. DSS shall allow all reports to be saved in multiple formats including but not limited to text and MS EXCEL.
3.17.008	The Vendor shall provide beginner and intermediate DSS training every month for up to twenty-four (24) Agency personnel. DSS Advanced training which includes temp tables, graphing, decision modeling and statistical modeling shall be provided once a quarter for up to twenty-four (24) Agency personnel. The training shall occur in a laboratory environment at the Agency.
3.17.009	The Vendor's DSS shall provide drill-down, graphing, decision modeling, statistical modeling, spreadsheet and geographic mapping capabilities and the capability to import external, geographically specific normative data for benchmarking during analysis. The Vendor's DSS shall maintain the capability to trend or compare information over various timeframes, make seasonal adjustments and display graphically. The Vendor's DSS shall have the ability to visually present information in tabular and graphic/chart form, including econometric and time series analysis and reporting.
3.17.010	The Vendor shall provide a full-time DSS Technician on site at the Medicaid Agency with knowledge of MMIS program operations, DSS modeling and reporting capabilities to support the Agency super-users. The Vendor's technician shall assist Agency staff in utilizing the DSS/Ad Hoc Reporting capabilities, including assistance with the development and maintenance of ad-hoc and/or stored queries. This shall also include expert technical assistance in mapping data by geographic regions, designing queries, pre-programmed reports, and in the development of graphs.
3.17.011	The Vendor's DSS shall also have support of a Web Master/HTML Programmer, a Network Specialist, a Security Administrator and a Data Base Administrator (DBA). All afore mentioned staff must be available within three (3) hours of Vendor identification or

New #	DSS Requirements
	notification of problem.
3.17.012	The Vendor's DSS load shall use a documented and Agency approved Extract Transform and Load (ETL) process to populate data warehouse tables. The ETL shall extract necessary data from the MMIS and load the data to the data warehouse.
3.17.013	The Vendor's DSS WAN/LAN user interface and WEB portal interfaces shall meet or exceed HIPAA and Medicaid's privacy and security standards. The Vendor shall maintain a secure DSS WEB portal with industry standard data encryption that emulates the functionality of the WAN/LAN DSS user interface.
3.17.014	The Vendor shall provide a user interface (UI) for the WAN/LAN network and WEB portal that facilitates flexible, mouse-driven navigation through all DSS capabilities and data. DSS shall provide a user-friendly, interactive interface suitable for specifying report selection, sort and display characteristics for most reporting needs.
3.17.015	The Vendor shall provide test results and supporting documentation for all canned queries. The queries must be approved by the Agency before being made available to the DSS users.
3.17.016	The Vendor's issue resolution/Change request process shall include a review of canned queries for impact. The canned queries shall be maintained/modified by the Vendor as part of the issue resolution/change request process. The Vendor's issue resolution/change request documentation shall include a validation of all modified queries and analysis of all canned queries.
3.17.017	The Vendor shall validate all pre-produced and pre-programmed queries and receive Agency approval prior to being finalized/canned.
3.17.018	The Vendor shall maintain and/or modify all canned queries as changes are made to the systems or issues are identified and resolved within the system.
3.17.019	The Vendor shall provide complete and comprehensive documentation and user manuals on-line on DSS capabilities to enable users to perform report drill down, decision and statistical modeling, mapping data by geographic regions, designing queries and pre-programmed reports, and in the development of graphs. The user manual shall include how to use the features of the DSS, instructions for completing requests for ad hoc reports, sample report formats, lists identifying DSS data available for reporting and other information as defined by the Agency. The user manual must be approved by the Agency.
3.17.020	The Vendor shall supply the Business Objects user manual either online or two (2) hard copies to the Agency within one (1) month of go live or update. The manual should be kept current with the version of Business Objects/Data Intelligence in use by the Vendor.
3.17.021	The Vendor shall provide tools to detect, analyze and report patterns and trends in Medicaid program expenditures, utilization, program operations and in access to care
3.17.022	The Vendor shall ensure the DSS is available twenty-four (24) hours a day between 7:00 AM Monday morning until 10:00 PM Saturday evening this shall include password reset capabilities.
3.17.023	The Vendors shall provide the capability to schedule batch queries to execute at future dates and times.
3.17.024	The Vendor's DSS shall have the capability to move claims history from one (1) recipient ID to another when the changes are made to the MMIS.
3.17.025	The Vendor's DSS shall provide advanced capabilities to support provider auditing activities and civil and criminal investigations of providers and beneficiaries.
3.17.026	The Vendor shall maintain capability to easily export copies of data from the system to varied desk-top computer applications, including spreadsheets and statistical packages. The Vendor shall maintain the ability to extract copies of data and reports and the ability to print and electronically share DSS report formats and report output with other users throughout the system network.
3.17.027	The Vendor's DSS shall Maintain selected user queries as stored queries available to all users. This should include the following documentation: what the query does, fields used in

New #	DSS Requirements
	the query, calculations performed by the query and valid values for prompted fields which will allow the users to qualify the query to better meet their needs.
3.17.028	The Vendor shall have documented procedures that have been approved by the Agency to manage user ID additions, removals and password reset functions. The Vendor shall provide authorized password reset request capabilities for DSS WEB portal users twenty-four (24) hours a day between 7:00 AM Monday morning until 10:00 PM Saturday.
3.17.029	The Vendor's DSS shall export data to a budget management module to provide advanced capabilities and attributes for monitoring, tracking and reporting, analyzing and projecting Medicaid benefit expenditures, including current and historical comparisons of expenditures to budgeted amounts. The Vendor must assure that data provides advanced capabilities and attributes for monitoring, tracking, reporting, analyzing and projecting information on all aspects of claims processing, prior approvals and TPL.
3.17.030	The Vendor's DSS shall provide the capability for interactive financial analysis and reporting.
3.17.031	The Vendor shall develop a utilization management module that will provide comparative information on fee for service and managed care program utilization and expenditures. This module must include the clinical and financial performance of providers and managed care entities. The module must provide access and support for Agency quality assurance activities for the monitoring, tracking, reporting, analysis and projection of beneficiary information. This includes comparative information on fee for service and managed care program access.
3.17.032	The Vendor shall provide costs and service utilization trends by which capitation models can be fully examined.
3.17.033	The Vendor's DSS shall maintain a minimum of sixty (60) months of claims data (including drugs) to support reporting, including complete reference, provider, recipient and Agency defined claims extract data.
3.17.034	The Vendor shall provide a query management tool to monitor and tune the database. This tool shall capture information about data queries generated by users; and shall produce reports monthly to the Agency to assist in analyzing query time, table structure, appropriate indexes, subjects for summary tables, fields actually being accessed and security (e.g., log in attempts). The reports shall be available to the Agency within two (2) days of the end of the month. The Vendor shall monitor the DSS service levels included in the reports. A 15% change in any area shall require the Vendor to research the issue. The Vendor shall provide a report of findings and a plan of action to prevent future occurrences of the problem to the Agency within five (5) days of the end of the month.
3.17.035	The Vendor shall ensure that the DSS extracts MMIS data accurately and timely in the required format. DSS shall include, at a minimum, all the data from the following: claims (Fee For Service and encounter), claims history (Fee For Service and encounter), NCPDP data (including "other coverage or reason code), encounter data and capitation records, provider (including imputed provider specialty), managed care (including case management fees), recipient (including recipient check digit, dual eligible groupings and net voucher data), reference, pharmacy information (including preferred drug data), third party liability (TPL) (including TPL remittance advice data), long term care (including waiver information), prior authorization, financial, long term care, early periodic screening diagnosis and testing (EPSDT), management and administrative reporting (MAR), surveillance and utilization review (SUR) and federal, EDB data, referral indicator, procedure codes plus modifiers, dental detail tooth surface data and drug rebate (Federal and State/Supplemental). The DSS extract shall include Health Insurance Premium Payments (HIPP) indicator and Parts A and B Buy-In information (including Buy-in premiums).
3.17.036	The Vendor shall correct or provide analysis and estimated date of correction within three (3) days of Contractor notification of any issues or defects.
3.17.037	The Vendor's DSS WEB portal access must be with a minimum of Secure Socket Level 3.0 (SSL) and provide authentication, data integrity, data confidentiality, audit logging and

New #	DSS Requirements
	monitoring
3.17.038	The Vendor shall respond to a request for a new report or change to a report within three (3) days of the request. The response must be either the requested report or an analysis of the level of effort to create the report with an estimated completion date.
3.17.039	The Vendor's DSS reports that are predefined shall be delivered to the Agency in the format requested (electronic, in COLD or printed) within two (2) days of the request. With the exception of recipient datasheets which are required to be printed and delivered in one (1) day.
3.17.040	The Vendor shall provide data extracts to the Agency within three (3) days of the request. The Vendor shall provide the data extract or an analysis of the level of effort to create the extract with an estimated completion date.
3.17.041	The Vendor's DSS shall provide data in a format acceptable to business users. The Agency will approve all changes to the format of DSS data.
3.17.042	The Vendor shall respond to requests for technical assistance on using DSS reporting software within one (1) day of receipt of request from the Agency.
3.17.043	The Vendor's DSS shall have the capability to schedule and execute individual queries and daily batch report jobs on the server.
3.17.044	The Vendor's pre-defined EIS reports shall be produced within five (5) minutes of user request.
3.17.045	The Vendor shall re-index the Data Warehouse database tables when directed by the Agency within three (3) days.
3.17.046	The Vendor's future enhancements to WEB Portal for DSS shall provide for downloads and installation of new releases of the application via the WEB within two (2) days of the Vendor implementation of release.
3.17.047	The Vendor shall use Agency approved encryption software.
3.17.048	The Vendor's DSS system shall maintain links between recipient universe, provider universe, reference universe, and claims universe by date of service and paid date.
3.17.049	The Vendor's DSS shall maintain the capability to segregate and subtotal data by Medicaid program within reports.
3.17.050	The Vendor's DSS shall maintain the capability to defer interactive query to batch processing.
3.17.051	The Vendor's DSS shall accept, but not be limited to, the following user-input selection parameters: Recipient ID, Category of service, Recipient aid category, Claim type, Provider ID, Fund code, Provider type, Race, Provider specialty, Age/birth date, Recipient County, Sex, Dates of Service, Special program status, Type of Service code, County of provider, Eligibility periods, Date of payment, TPL data, Time Period, Bill Type, Procedure Codes, Flags, indicator and modifiers, Diagnosis Codes, Place of Service Codes, Primary Medical Provider, Prepaid Inpatient Health Plan, and Managed Care system.
3.17.052	The Vendor shall maintain the capability to carry all levels of recipient aid categories for “drilling down” to details, such as ages, location and retroactive eligibility.
3.17.053	The Vendor shall provide access to the DSS WAN/LAN user interface and WEB portal interface for all individuals or entities identified by the Agency. The Vendor shall provide all necessary hardware, software, telecommunications, user documentation, instructions, installation and ongoing maintenance, as necessary, for the proposed configuration.
3.17.054	The Vendor shall provide the capability to do random sampling, using standard statistical methodologies for monitoring functions.
3.17.055	The Vendor's DSS shall save report definitions on file and accept new requests and changes to existing batch and interactive reports.

New #	DSS Requirements
3.17.056	The Vendor's DSS shall have the capabilities to perform mathematical and statistical calculations such as, ratios & proportions, rates (e.g., birth and mortality), variance, standard deviation, confidence interval, mean, median, mode & ranges for the effective and accurate analysis and presentation of information on an interactive basis. It must provide capabilities for modeling and forecasting, including econometric and time series analysis and reporting.
3.17.057	The Vendor shall allow users to select at least eighteen (18) concurrent data dimensions with an unlimited number of user selectable or definable aggregation or disaggregation.
3.17.058	The Vendor shall produce electronic and printed reports from the Web audit log for the DSS Web portal monthly no later than the first business day of the month.
3.17.059	The Vendor shall provide decision support software for all Agency staff, contractors and business associates as designated by the Agency.
3.17.060	The Vendor's DSS shall have the capability to display claims that failed Edits and Audits in the Error Analysis Universe. (These claims would include claims that have been rejected by edits, audits and also claims that were paid but failed audits.) The Vendor's DSS shall have pre-defined (canned) reports that identify how many claims and total billed amount failed edits per provider, claim type, or error.
3.17.061	The Vendor shall provide extracts of claims data to external entities as directed by the Agency within five (5) days of request or on an Agency pre-defined schedule.
3.17.062	The Vendor's DSS shall reflect the current information in the MMIS including but not limited to: changes or additions to categories of service, recipient aid categories, recipient identification number changes, provider types and specialties, benefit plans, state categories of service, fund codes, reference data, TPL data and all claims data. The recipient identification number changes must be reflected in all recipient-related and claims-related universes.
3.17.063	The Vendor's DSS claims and financial data shall include but is not limited to: adjudicated, suspended, and encounter claims data, adjustments and financial transactions, for the reporting period, from the Claims Reporting function and the Managed Care function.
3.17.064	The Vendor shall meet with the Agency monthly to review the DSS priority list of changes or fixes and modify priorities. The Vendor shall work changes or fixes in the priority set by the Agency.
3.17.065	The Vendor shall maintain access to all TPL data through DSS. This shall include but not be limited to all Policy Segment, Trauma/Estate Recovery Case, Medicare, Carrier, Absent Parent, Medicare Advantage, and Accounts Receivable data. The Vendor shall maintain through DSS TPL-related claim data, including third party identifying information, COB data, claim override codes, and NCPDP other coverage payment and denial codes.
3.17.066	The Vendor's DSS shall allow Agency staff to produce management ad hoc reports through DSS.
3.17.067	The Vendor's DSS shall maintain the capability to produce a report identifying, by carrier code, outstanding TPL billings.
3.17.068	The Vendor's DSS shall maintain the on-line real-time capability to identify T/E cases that closed with no recovery and those for which payment was received.
3.17.069	The Vendor's DSS shall generate and store for on-line access, reports that depict the total TPL amounts billed by carrier and by recipient. The Vendor's DSS shall maintain the capability to obtain the amount recovered by carrier and/or recipient on the TPL A/R file.
3.17.070	The Vendor's DSS shall have pre-defined ("canned reports") that will serve as a tracking and reporting mechanism to inform the Agency's TPL unit when follow-up actions are needed for post-payment billing and T/E case tracking.
3.17.071	The Vendor's DSS shall provide the capability to query the monthly and yearly state aid category reports.
3.17.072	The Vendor's DSS shall have a pre-defined ("canned report") of hospital paid claims experience report.
3.17.073	The Vendor shall make DSS data available to produce control reports identifying service

New #	DSS Requirements
	outliers. The data shall include but not be limited to: age, sex, previous utilization and diagnosis.
3.17.074	The Vendor shall make DSS data available to report on recipient group utilization characteristics, including but not limited to types of services by program, eligibility category, and demographic characteristics (age, sex, place of residence, etc.).
3.17.075	The Vendor shall make DSS data available to report on Maternity Waiver Patient Profiles with the ability to produce query and ad-hoc reports.
3.17.076	The Vendor shall make DSS data available to report on program, provider, and recipient-specific service expense data, both historical and projected.
3.17.077	The Vendor shall provide the DSS data required to report on utilization expense analysis by member, per month.
3.17.078	The Vendor shall provide the DSS data required to report on monthly enrollment and participation reports on new and multiple plans. These reports include but are not limited to program, provider, recipient, age, sex, and aid category.
3.17.079	The Vendor shall maintain a process for the Agency to generate individual Recipient claim history requests from DSS. The process will access all claims history and all claim types. The report shall be produced by recipient (including merged recipient ID numbers). The report shall include a description of procedure, drug, diagnosis, error codes and provider name.
3.17.080	The Vendor's DSS shall provide the data and capability to accomplish retrospective collection and analysis of health services data on Medicaid recipients by PMP, medical group and prepaid inpatient health plan covering the areas of utilization/cost of services, membership data, access to care, coordination of care, quality of care and rate analysis to effect trend analysis, problem identification and resolution.
3.17.081	DSS shall provide necessary data to support the development of health services delivery standards/practice guidelines that can be used in the ongoing monitoring and measurement of health plans' performance in the delivery of services, in providing member access to health care, member satisfaction, membership stability and demographics as well as resource allocation within the plan and in achieving financial stability.
3.17.082	The Vendor's DSS shall provide for utilization/cost reporting to monitor the usage and cost of services rendered at different hierarchies (e.g., aggregating and reporting utilization data by PMP, prepaid inpatient health plans and type of service and/or accumulating and reporting utilization data by recipient, prepaid managed care plan, county, Medicaid aid category, benefit package and age-sex combinations for financial management purposes).
3.17.083	The Vendor's DSS shall provide the data needed to perform exception processing for recipient and provider groups (i.e., recipient with peer groups for comparative analysis).
3.17.084	The Vendor's DSS shall provide the data needed for detailed utilization/cost data to establish equitable capitation rates, determine the overall cost-effectiveness of the prepaid Medicaid program and compare prepaid costs with those incurred by an analogous FFS population.
3.17.085	The Vendor's DSS shall provided the data needed to produce a comprehensive range of essential statistical population reports, membership listings, and reports on membership data at multiple levels including member, managed care plan, county, and statewide.
3.17.086	The Vendor shall provide one (1) full-time DSS technical support person to work full time at the Agency. The DSS support person will have sufficient technical knowledge of MMIS program operations, EIS/DSS modeling and reporting capabilities to support the Agency in generating DSS queries and reports. The Vendor's support person will assist the Agency staff in utilizing the EIS/DSS /Ad Hoc Reporting in designing stored queries (pre-produced reports) and pre-programmed reports, in graphing and mapping data.

New #	DSS Requirements
3.17.087	The Vendor shall define a set of benchmark queries that shall be approved by the Agency. The benchmark queries shall be run on an Agency approved schedule. The Vendor shall perform an analysis of the benchmark queries and provide a report of the analysis to the Agency with two (2) days of the end of the month. A 25% change in any benchmark query shall require the Vendor to research the issue. The Vendor shall provide a report of findings and a plan of action to prevent future occurrences of the problem to the Agency within five (5) days of the end of the month.
3.17.088	The Vendor's DSS shall maintain the capability to defer an interactive query to batch processing. The Vendor shall plan and execute batch report cycles on a daily basis.
3.17.089	The Vendor shall provide a secure Web portal that shall allow access to DSS via the Internet for up to thirty (30) Agency staff. The Web portal DSS shall provide full access to the DSS server which includes creating ad-hoc queries. The Vendor shall provide any additional training required to access DSS through a secure Web portal.
3.17.090	The Vendor's DSS shall provide the capability to run large queries overnight from a desktop and in batch mode on the DSS server. Batch system outputs shall be in a format approved by the Agency. The Vendor's batch system shall notify the user when processing completes. The Vendor shall FTP completed batch jobs to the user upon request.

3.18 Comprehensive Recipient On-line Collections System (CROCS) Requirements

CROCS (Comprehensive Recipient On-line Collections System) is used to register and confirm recipient overpayments, generate recipient overpayment letters, and track accounts receivable transactions for those recipients who have had services paid in error. The payments received from Medicaid recipients are manually entered into the on-line system. CROCS interfaces with the AMMIS to capture selected recipient information, but it is not currently a part of the AMMIS. The system maintains an Accounts Receivable file to be used to identify recipients and track the payments received as well as transmits information regarding Tax Intercept to the State of Alabama Department of Revenue.

The following are the requirements identified by the Agency that must be met by the Vendor to support the successful operation of the CROCS related functions.

New #	CROCS Requirements
3.18.001	The Vendor shall produce a report monthly of all active recipient accounts receivable information. This report shall be available the first working day of the month.
3.18.002	The Vendor shall produce a report monthly of all recipients whose accounts receivables have a negative balance. This report shall be available the first working day of the month.

New #	CROCS Requirements
3.18.003	The Vendor shall provide a panel that the Agency will use to update the recipient overpayment amount. The panel will pull the recipient information from the recipient master file. The panel shall allow the Agency to request an initial notice. An additional notice shall be generated by the system thirty (30) days after the initial notice. The Vendor shall allow the Agency to force a notice at anytime. The Vendor shall produce the notices using a template approved by the Agency. The notices shall systemically populate with all the recipient and CROCS information. The Vendor shall produce the notices in a format that can be updated and or modified in MSWord.
3.18.004	The Vendor shall maintain recipient accounts receivable amounts until the accounts are closed (from one fiscal year to the next).
3.18.005	The Vendor shall identify those individuals or entities subjected to Tax Intercept. The criteria for Tax Intercept shall be defined by the Agency.
3.18.006	The Vendor shall generate and transmit the Tax Intercept information to the State Department of Revenue via the current Dept. of Revenue approved method no later than the last business day of the year. The information shall include but not be limited to name, social security number, reason for debt and amount of debt.
3.18.007	The Vendor shall generate and mail Tax Intercept notification letters to recipients, sponsors or other responsible parties by October 15th, of each year. Any letter returned to the Vendor shall require the Vendor to verify the recipient information and re-mail if a newer address or information is available.
3.18.008	The Vendor shall maintain on-line real-time access and update capability to an accounts receivable file which processes and reports financial transactions by type of transaction and recipient. The file shall include but not be limited to: - Recipient name and number - Sponsor name - Account balance - Reason indicator - Type of collection - Program and Collection Authority - Tax Intercept indicator
3.18.009	The Vendor shall maintain on-line real-time update and inquiry to financial information with access by Recipient ID and by Recipient Name; to include but not be limited to: - Overpayment information - Receivable account balance and established date - Type of collections made, amount and date - Deposit date
3.18.010	The Vendor shall maintain a panel to support online real-time reports on recipient accounts receivable collections and outstanding balances in aggregate and/or individual accounts as approved by the Agency. The report shall be available daily, weekly and monthly.
3.18.011	The Vendor shall pull the Recipient and sponsor data from the MMIS for use in the CROCS.

3.19 Integrated Test Facility (ITF) Requirements

The Integrated Test Facility (ITF) allows the Agency and the Vendor to monitor the accuracy of the AMMIS and test proposed changes to the system by processing test claims and other transactions through the system without affecting normal operations.

Quality control is the system of internal controls that the Vendor utilizes in the operation of the MMIS. Assurance of quality in implementing system changes and for ongoing operations is achieved through two (2) MMIS test systems.

1. **User Acceptance Test (UAT)** - a test environment is designed to allow the Agency to test changes. The UAT is a mirror image of the production environment with the exception of UI changes which move to UAT prior to the production release.

2. **Model Office (MO)** – a test environment is designed to allow the Vendor to test changes before the changes are moved to the User Acceptance Test (UAT) environment. The MO is defined to the Vendor specifications.

The following are the requirements identified by the Agency that must be met by the Vendor to support the successful operation of the Integrated Test Facility related functions.

New #	Integrated Test Facility Requirements
3.19.001	The Vendor shall provide at a minimum five (5) days to review test results. Any test results with less than a five (5) days review time will require the Vendor to schedule an on-site review at the Agency. All test results must have the approval of the function process owner before being moved to production.
3.19.002	Any data or transactions from a test environment shall not be included in production reports or counts.
3.19.003	The Vendor shall develop and maintain the procedure documentation for system change, development and test processes. The documentation and process shall be approved by the Agency.
3.19.004	The system shall contain more than one (1) integrated test facility region. The purpose of providing multiple test regions is to ensure the stability of the system and the data when major enhancements are being tested. This shall allow the Vendor to make changes without having to freeze the system or data at the expense of other system changes (i.e., testing new edit logic).
3.19.005	The Vendor shall provide the Agency with on-line access to all test environments and all test files to submit test data independently.
3.19.006	#1 UAT (User Acceptance Test) - An integrated test facility is designed to allow test claims to be processed through a simulated production environment. The UAT will contain full copies of all production data except claims. Production claims will only be in UAT for selected Agency approved recipients. The financial cycles from UAT shall not result in payments by EFT or printed checks. All reports and files will be available in a storage area clearly identified and different from production. The data from the UAT environment shall be exported to UAT DSS (Decision Support System).
3.19.007	The system shall allow on-line real-time updates to all functional areas in UAT. The changes

New #	Integrated Test Facility Requirements
	shall include but not be limited to recipients, providers, claims, financial, reference, Waivers, Long Term Care, Patient 1st, PA and TPL.
3.19.008	There shall be a point of contact identified for UAT paper claims, PA and consent forms. These will need to be processed for the UAT, scanned and stored in a report repository or repository folder other than production. The requested updates shall be made within two (2) days of receipt of the request.
3.19.009	Claim copies, adjustments and consent forms shall be stored in a report repository or repository folder other than production.
3.19.010	The Vendor shall not process checks or EFT for UAT providers.
3.19.011	The Remittance Advices (RAs) and reports shall be created after each UAT cycle and stored in the UAT report repository. They are not to be included in any production reports or counts. The cycle shall be run on an Agency approved schedule. All UAT cycle reports shall be generated no later than the first business day after the scheduled cycle.
3.19.012	The UAT shall accept claims data from the Web, the Provider Electronic Solution Software (PES), ECM and other electronic claim submission methods, without notice to the Vendor, in hard-copy or electronic format.
3.19.013	There shall be an automated testing software available for Agency use such as the current TTG (test transaction generator). The test transactions can process and be committed to history or execute edits and audits only. The Agency shall have the ability to store test cases for reuse.
3.19.014	The Vendor must have a set of Agency approved claims that run using an automated testing software after each UAT software release. The Vendor shall provide a report from the automated testing software that contains any claims that did not pay as expected. The Vendor shall also research and document the reason for the discrepancy. This documentation shall be available to the Agency within two (2) days of the software release being applied to the UAT environment.
3.19.015	The Vendor shall refresh all UAT data on a schedule approved by the Agency or at Agency request.
3.19.016	#2 Test Environment (Model Office) - The test facility shall enable the Vendor to perform computer runs against test files using current production software containing the modifications to be tested. This function shall be utilized by the Vendor to test software changes, parameter and criteria file changes and other modifications which must be completely tested before moving to the UAT and production environment.
3.19.017	The inputs to Model Office shall include but not be limited to claims (all claim types), all methods of claims entry, adjustments, refunds and other production transactions.
3.19.018	The data in Model Office shall include but not be limited to adjudicated claims history, financial, reference, PA, TPL, LTC, Managed Care, recipient and provider.
3.19.019	Model Office shall generate output, including but not limited to files, reports, tapes, etc., to be separately identified and clearly labeled.
3.19.020	Model Office shall perform claims and adjustment processing in a simulated production environment for all functions except for issuing a payment.
3.19.021	Model Office shall accept claims data from the Web, the Provider Electronic Solution Software (PES), ECM and other electronic claim submission methods, without notice to the Vendor, in hard-copy or electronic format.

New #	Integrated Test Facility Requirements
3.19.022	Model Office shall perform claims and adjustment processing in a simulated production environment.
3.19.023	Model Office reports shall be generated and stored in a clearly defined area that does not contain reports from other environments such as production. All reports including RA's shall be produced, but no payments shall be generated.
3.19.024	The Vendor shall refresh all Model Office data at least quarterly.

BIDDER RESPONSE FORMAT

4.01 General Response Requirements

This section describes the format and requirements for the Bidder's submission of their bids. Bidders shall build their bid responses according to the formats, requirements and the order of items as defined in each section below. Each Bidder's bid response shall be divided into two parts as described in *Section 4.03 Transmittal Letter* and *Section 4.04 Bid Response Requirements* in addition to providing the required number of copies as specified in *Section 4.02 Bid Response*.

4.01.01 Bid Submission Requirements

Sealed bid packages shall be mailed to:

State of Alabama
Department of Finance
Division of Purchasing
PO Box 302620
Montgomery, Alabama 36130-2620
Attention: Ray Bressler

or delivered to:

State of Alabama
Department of Finance
Division of Purchasing
RSA Union Building
100 North Union Street, Suite 192
Montgomery, Alabama 36104
Attention: Ray Bressler

Bids submitted, in whole or in part, by modem or fax will be rejected. Late responses will not be accepted.

Bids must be received by the Division of Purchasing no later than the date and time specified in the *Section 1.05 - Schedule of Activities*. It is the responsibility of the Bidder to ensure the bid is delivered by the time specified. Bids received after that time will not be considered.

Bidders must submit the documents outlined in the following subsections to the Division of Purchasing.

4.02 Bid Response

Bidders must submit one (1) original and ten (10) hard-copy versions plus two (2) electronic versions on CD/DVD of the Bid Response. The original hard-copy version shall be identified as such and shall include the transmittal letter with the original signature. Electronic versions shall be submitted in Microsoft Word 2007 or Adobe PDF version 7 or higher.

The Bid Guarantee in the amount of three hundred thousand dollars ($300,000) must be included in the original hard-copy version of the Bid Response.

4.02.01 Pricing Response

The State of Alabama Invitation To Bid Form, Pricing Schedule and any addenda must be included in the original hard-copy version of the bid. The forms must be signed in ink by the Bidder or an officer of the Bidder who is legally authorized to bind the Bidder to the bid. Bids which are determined to be at variance with the requirements as stated on the forms will not be accepted.

4.02.02 Packaging Requirements

The outside cover of the sealed box containing the Bid Responses and the required documents shall be clearly marked as follows:

- BID RESPONSE
- BIDDER'S NAME
- ITB #10-X-2205737
- PROPOSAL DUE DATE AND TIME

Submission of a bid shall constitute recognition, understanding, acceptance, and consent by the Bidder to adhere (without any reservation or limitation whatsoever) to the requirements, terms, and conditions of this ITB, including any ITB addenda. This consent to adhere to requirements shall also apply to the use of all pricing schedules contained in *Section 7.07 Appendix G – Pricing Schedules* and all related cost information.

4.02.03 Freedom of Information and Privacy Acts

Bidders should be aware that all materials associated with the procurement are subject to the terms of the Freedom of Information Act, and all rules, regulations, and interpretations resulting there from including those from the Offices of the Attorney General of the United States, Health and Human Services (HHS), and Centers for Medicare and Medicaid Services (CMS).

By submission of a bid, the Bidder agrees that the Privacy Act of 1974, Public Law 93-579, and the Regulations and General Instructions issued pursuant thereto are applicable to this contract, and to all subcontracts hereunder to the extent that the design, development, operation, or maintenance of a system of records as defined in the Privacy Act is involved.

4.03 Transmittal Letter

The Transmittal Letter shall be submitted on official business letterhead by the prime contractor and shall be signed by an individual authorized to commit the company to the scope of work proposed.

1. The Transmittal Letter shall contain all of the following:

    a. Identification of all materials and enclosures being submitted collectively as a response to this ITB.

    b. A statement identifying each addendum to this ITB that has been received; if no addenda have been received, a statement to that effect shall be included. The Bidder shall list each ITB addendum received by addendum number.

    c. Identification of the Bidder who will be the prime contractor and the name of the corporation or other legal entity submitting the proposal. It shall also include a statement identifying any and all subcontractors, if any, who are needed in order to satisfy the requirements of this ITB. The percentage of work, as measured by percentage of total contract price, to be performed by the prime contractor shall be provided. Subcontracted work shall not, collectively, exceed forty percent (40%) of the total contract price. The Bidder shall assume sole and exclusive responsibility for all of the Contractor Responsibilities and work indicated in the ITB (including any and all addenda). If no subcontractor is proposed a statement shall be made identifying that fact.

    d. A statement certifying that, if a foreign corporation, the Bidder has a current Certificate of Authority to do business in Alabama issued from the Alabama Secretary of State.

    e. A statement of compliance with Affirmative Action and Equal Employment Opportunity regulations that confirms that the Bidder does not discriminate in its employment practices with regard to race, color, religion, age (except as provided by law), sex, marital status, developmental disability, political affiliation, national origin, or handicap, and complies with all applicable provisions of Public Law 101-336, Americans with Disabilities Act.

    f. A statement that the Bidder will provide staffing resources adequate to meet all requirements in every phase of this ITB and further, in regard to the Operations Phase, guarantees to meet the requirements of *Section 3 - Requirements*.

g. A statement that the Bidder's proposed solution will:

- meet the specifications set forth in this ITB,
- continue to meet CMS certification requirements, and
- meet all performance standards and expectations set forth in this ITB.

h. A statement acknowledging and agreeing to all of the rights of the Agency contained in the provisions of this ITB, including procurement rules, terms and conditions, and all other rights and terms specified in this ITB.

i. A statement that the Bid Response is valid for a minimum of nine (9) months from the bid submission date.

j. A statement that the prices proposed were arrived at independently without consultation, communication, or agreement with any other Bidder or competitor for this procurement.

k. A statement that the Bidder, through its duly authorized representatives, has in no way entered into any arrangement or agreement with any other Bidder or competitor which could lessen or destroy free competition in awarding the contracts.

l. A statement that the Bidder has not and will not make any attempt to induce any other person or firm to withhold or submit a proposal for the purposes of restricting competition.

m. A statement that the person signing this bid is authorized to make decisions on behalf of the Bidder's organization as to the prices quoted.

n. A statement that the Bidder has not employed anyone, other than a bona fide employee working solely for the Bidder, in soliciting or securing this contract.

o. A statement that no person or agency has been employed or retained to solicit or secure the proposed contract based on an agreement or understanding for a commission, percentage, brokerage, or contingent fee.

p. A statement that the Bidder and any subcontractors will maintain a drug-free workplace.

q. A statement that neither the Bidder nor any subcontractor has received nor will receive any compensation from the State for participation in preparation of this ITB.

r. A Disclosure Statement completed and submitted with the bid required pursuant to Alabama Act 2001-955, located in *Section 7.16 - Appendix P – Disclosure*

Statement or on the Attorney General's web site at the following address: http://www.ago.state.al.us/ag_items.cfm?Item=70

2. If the use of subcontractors is proposed, a statement from each subcontractor, on official letterhead, shall be attached to the Transmittal Letter, signed by an individual authorized to legally bind the subcontractor to perform the scope of work as assigned, stating:

   a. The general scope of work to be performed by the subcontractor.

   b. The subcontractor's willingness to perform the work indicated.

   c. The names and titles of individuals who will be responsible for the subcontractor's efforts.

   d. That the subcontractor's firm does not discriminate in its employment practices with regard to race, color, religion, age (except as provided by law), sex, marital status, developmental disability, political affiliation, national origin, or handicap, and complies with all applicable provisions of Public Law 101-336, Americans with Disabilities Act.

   e. If subcontractors will not be used on this project, include statements in this section to specify your company's intentions not to use subcontractors. Title this section as "**Use of Subcontractors"** in your Business Response.

3. Bidders must explicitly identify and explain any and all deviations from the detailed specifications and requirements of this ITB. Bidder acknowledges that any such deviations may result in the rejection of their bid at the sole discretion of the Agency.

4.04 Bid Response Requirements

The Bid Response must present a complete and detailed description of the Bidder's qualifications to perform and its approach to carry out the requirements in *Section 3 - Requirements*, of this ITB. Any deviations in the Bidder's Bid Response from the outline described below could disqualify that bid due to evaluation considerations. The name and number of this ITB shall be included on the title page of each volume.

4.04.01 Business Experience Matrix

Provide the *Section 7.12 Appendix L - Business Experience Matrix* which summarizes relevant projects completed by your firm, or the specific organizational unit of your firm that will be responsible for work performed in this contract. List all claims processing related projects worked in the last ten (10) years. All projects must be listed if your firm has less than ten (10) relevant projects. The matrix must provide all of the information described below. Columns for the Business Experience Matrix should be used as follows:

- ***Row 1: Bidder's Name –*** Please enter your company name in row 1 column B.

Beginning in row 3 please enter the pertinent information for the past 10 years:

- ***Column A: Project Name –*** A name for the project that the client will recognize.

- ***Column B:*** **Client Information –** Name, address, fax number, telephone number and email for the client**.**

- ***Column C:*** **Client Contact information –** Contract name, address, fax number, telephone number and email address of an individual who was employed by the client and is knowledgeable about this project.

- ***Column D: MMIS*** **-** Indicate if work was performed relative to design and implementation for State Government MMIS. Indicate Yes or No in box.

- ***Column E:*** **Summary -** Summary of the work performed by the Bidder on the project. The summary shall include the types of claims processed by the system, a description of the Bidder's responsibilities under the contract and if the work was done as part of an MMIS implementation whether the system was transferred, new or a takeover of the existing system.

- ***Column F:*** **Original Start Date -** For each project, indicate the original starting date of the project using Month/Day/Year (MM/DD/YY) format.

- ***Column G:*** **Actual Start Date -** For each project, indicate the actual starting date of the project using Month/Day/Year (MM/DD/YY) format.

- ***Column H:*** **Original End Date -** For each project, indicate the original ending date of the project using Month/Day/Year (MM/DD/YY) format.

- ***Column I:*** **Actual End Date -** For each project, indicate the Actual ending date of the project using Month/Day/Year (MM/DD/YY) format.

- ***Column J:*** **Scope and Budget –** Use this box to identify projects that were completed within the original scope and budget. Indicate Yes or No in box.

- ***Column K:*** **Litigation -** Check this box if your firm was involved in any litigation related to this project. Indicate Yes or No in box.

- ***Column L:*** **Contract changes or amendments –** Use this column to identify any contract changes or amendments that occurred before the actual end date of project.

- ***Column M:*** **If the project was not on schedule at the time of contract changes or amendments how far behind was the project? –** Use this column to indicate how far the project was behind before contract changes or amendments. If the project was not behind indicate zero (0).

- ***Column N:*** **Prime or Subcontractor –** Indicate whether your corporation served as prime or a subcontractor on this project.

- ***Column O:*** **Other Information –** Provide explanations of any schedule delays, litigation, contract changes, amendments or other pertinent information.

Medicaid reserves the right to contact any former client or employer with which the Bidder is known to have done business, whether provided as a reference or not.

4.04.02 Bid Response Sections

The Bid Response shall include seven (7) separate sections (with named and numbered tabs for the original and all copies) presented in the following order:

- Tab 1A - Transmittal Letter (*Section 4.04.03*)

- Tab 1B - Bid Guarantee (*Section 4.04.04*) - *Original Volume only*

- Tab 1C – Statement of Alabama Invitation to Bid Form and Pricing Schedules (A, B, C, & D) (*Section 4.04.05*) - *Original volume only*

- Tab 2 - Table of Contents (*Section 4.04.06*)

- Tab 3 - Executive Summary (*Section 4.04.07*)

- Tab 4 - Approach to the Implementation Phase (*Section 4.04.08*)

- Tab 5 - Operations Phase (*Section 4.04.09)*

- Tab 6 - Corporate Capabilities and Commitments (*Section 4.04.10*)

- Tab 7 - Appendix (*Section 4.04.11*)

Note: The ITB references above are suggested to assist the Bidder in preparing the bid response and are not intended to be the sole ITB references.

The format and contents for the material to be included in each of these sections is described below. Each section within the Bid Response shall include complete responses to all required items listed under each heading. The evaluation of Bid Responses will be organized to follow the submission format. Therefore, Bidders are advised to follow the defined format and to clearly identify the location of topics in their response.

Each Bid Response (including all copies thereof) shall be:

a) submitted in three (3) ring binders,

b) 8.5 x 11-inch paper and two-sided copies,

c) type size of eleven (11) points or larger shall be used, except in tables and charts where a type size of ten (10) points is acceptable, and

d) clearly page-numbered on the bottom (center or right) of each page.

Brochures or other presentations, beyond that sufficient to present a complete and effective response, are not desired. Audio and/or videotapes are not allowed. Elaborate artwork or expensive paper is not necessary or desired.

The Division of Purchasing desires and encourages that bids be submitted on recycled paper, printed on both sides. While the appearance of proposals and professional presentation is important, the use of non-recyclable or non-recycled glossy paper is discouraged.

A maximum page limit has been set for some sections of the Bid Response. Bidders are required to respect these page limits to facilitate a timely and responsive evaluation. Pages in excess of these limits will be removed during the Mandatory Requirements Phase of evaluation.

4.04.03 Transmittal Letter – Tab 1A

The Transmittal Letter shall be bound into the original volume and all copies of the Bid Response.

4.04.04 Bid Guarantee – Tab 1B

The Bid Guarantee shall be bound in the original volume of the Bid Response.

4.04.05 State of Alabama Invitation to Bid Form and Pricing Schedules – Tab 1C

The Alabama Invitation to Bid Form and Pricing Schedules shall be bound into the original volume of the Bid Response.

4.04.05.01 Pricing Schedule Requirements

The Bid Response will be the Bidder's total Fixed Price Bid representing the fixed, not estimated, costs that the Bidder requires in order to complete this project according to the requirements of the ITB. Estimated Total Fixed Price cost responses will not be evaluated, will not be considered and will be deemed non-responsive. Bidders will not be considered to be responsive if "Total Implementation Cost" bid on Pricing Schedule B(I) - Implementation Costs for Incumbent Vendor or Pricing Schedule B(N) Implementation Costs for Non-incumbent Vendor, exceed twenty-five percent (25%) of "Total Price" from Pricing Schedule A(I) - Evaluated Price for the Incumbent Vendor or Pricing

Schedule A(N) Evaluated Price for the Non-incumbent Vendor. Payments will be based upon contracted services actually performed in accordance with the proposed Fixed Price as indicated in the following documents:

- State of Alabama Invitation to Bid Form
- Pricing Schedule A(I) Incumbent Vendor - Total Evaluated Price or Pricing Schedule A(N) Non-incumbent Vendor - Total Evaluated Price
- Pricing Schedule B(I) - Incumbent Fixed Price - Implementation Costs or Pricing Schedule B(N) - Non-incumbent Fixed Price - Implementation Costs
- Pricing Schedule C(I) - Incumbent Fixed Price - Operations Cost or Pricing Schedule C(I) - Non-incumbent Fixed Price - Operations Cost
- Pricing Schedules D(I) D-1 through D-8 Incumbent Labor Rates for Changes or Pricing Schedules D(N) D-1 through D-8 Non-incumbent Labor Rates for Changes.

The Bid Response pricing schedules are included in *Section 7.07 Appendix G – Pricing Schedules* of this ITB and are available for download on the web at www.medicaid.alabama.gov, by written request or at the Pre-Bid Conference. These electronic forms should be completed printed and submitted in paper form to the State. Where a signature block is indicated, the pricing schedule must be signed and dated by an appropriate corporate official. The pricing schedules may be reproduced by the Bidder, however, no deviations in the format or content of the pricing schedule is permitted. Any such deviations could result in the Bidder's response being found non-responsive.

Since the incumbent Contractor should have lower implementation costs, all implementation figures are discounted by twenty percent (20%) in the evaluated implementation cost to encourage competition.

4.04.05.01.01 Pricing Schedule A(I) and A(N)

Pricing Schedule A(I) must be completed by the Incumbent Vendor and Pricing Schedule A(N) must be completed by the Non-incumbent Vendor.

For purposes of award, the low Bidder will be determined based upon total price from Schedule A(I) and A(N) and also reflected on the Invitation to Bid form. The Bidder shall enter all costs from Schedules B(I), C(I) and D(I) in the appropriate month on Schedule A(I) for the Incumbent Vendor and from Schedules B(N), C(N) and D(N) in the appropriate month on Schedule A(N) for the Non-incumbent Vendors. A signature on this pricing form is required.

For implementation costs from Schedule B(I) and B(N), the Agency has estimated the month on Schedule A(I) and A(N) in which each milestone will be completed and paid. Bidders should propose actual delivery dates in its work plan according to the solution being offered.

4.04.05.01.02 Pricing Schedule B(I) and B(N)

Pricing Schedule B(I) must be completed by the Incumbent Vendor and Pricing Schedule B(N) must be completed by the Non-incumbent Vendor.

Pricing Schedule B(I) includes all Enhancement deliverables and implementation charges expressed as a firm fixed price. The Bidder shall submit a fixed price for each of the deliverables identified on Schedule B(I). The amount bid for each task cannot exceed the threshold identified on Schedule B(I). The price quoted shall be the total price to bring the modified AMMIS to full operational status, including final federal recertification if required. A signature on this pricing form is required.

Pricing Schedule B(N) includes all Operations and Enhancements deliverables and implementation charges expressed as a firm fixed price. The Bidder shall submit a fixed price for each of the deliverables identified on Schedule B(N). The amount bid for each task cannot exceed the threshold identified on Schedule B(N). The price quoted shall be the total price to bring the modified AMMIS to full operational status, including final federal recertification if required. A signature on this pricing form is required.

4.04.05.01.03 Pricing Schedule C(I) and C(N)

Pricing Schedule C(I) must be completed by the Incumbent Vendor and Pricing Schedule C(N) must be completed by the Non-incumbent Vendor.

The Base Price is defined as those costs the Bidder will incur regardless of the number and type of claims. Some examples of costs that should be included in the Base Price are fixed costs such as salaries, rent, equipment (including phone systems, computers and telecommunication lines that are **not** separately reimbursed as a pass-through expense), travel, training, furniture and utilities.

The "Total Monthly Price" must be entered on Schedule A(I) for the Incumbent Vendor or Schedule A(N) for the Non-incumbent Vendor for the indicated months. A signature on this pricing form is required.

4.04.05.01.04 Pricing Schedules D(I) and D(N) D-1 through D-8

Pricing Schedule D(I) must be completed by the Incumbent Vendor and Pricing Schedule D(N) must be completed by the Non-incumbent Vendor.

These pricing schedules will be used to develop the Bidder's total evaluated price quotations for extra contractual services. A signature on these pricing forms is required.

4.04.05.01.04.01 Pricing Schedule D-1

Pricing Schedule D-1 summarizes the total additional labor costs for each of the seven (7) contract years quoted on Pricing Schedules D-2 through D-8. Enter the amounts from Pricing Schedules D-2 through D-8 in Boxes 1, 3, 5, 7, 9, 11 and 13 respectively. Enter the amounts from Price Schedule D-1, Boxes 2, 4, 6, 8, 10, 12 and 14 in the appropriate

boxes on Schedule A(I) for the Incumbent Vendor or Schedule A(N) for the Non-incumbent Vendor.

4.04.05.01.04.02 Pricing Schedules D-2 through D-8

The Bidder shall specify the labor rates for the personnel listed. The hourly rates quoted shall remain firm for the stated contract year and shall be used to develop price quotations for extra contractual services. The hourly rates specified for each personnel category should be multiplied by the hours indicated to arrive at the Evaluated Cost for that category. The sum total Evaluated Cost for all personnel categories will be entered in the Total Additional Year Labor Costs box and entered on the corresponding line of Schedule D-1.

4.04.06 Table of Contents – Tab 2

The Bid Response shall contain a Table of Contents with titles for each section and beginning page numbers.

4.04.07 Executive Summary – Tab 3

The Executive Summary section shall summarize and highlight the contents of the Bidder's Bid Response in such a way as to provide the Evaluation Committee with a broad understanding of the entire Bid Response. The Executive Summary is limited to twenty-five (25) pages and shall include the following:

a. A clear and concise summary of the Bidder's understanding of the project and Alabama's MMIS needs.

b. A clear and concise summary of the proposed design and development approach, the staffing structure, and the Implementation Phase schedule.

c. A general description of the capabilities and planned roles of any proposed subcontractor(s).

d. A summary of the requested enhancements to the AMMIS - This summary shall include a brief description of each enhancement to the AMMIS and any changes to how the AMMIS should operate. This summary shall in no way change the requirements as defined in *Section 3 - Requirements*.

e. A brief description of the major benefits offered by this proposal.

f. A description of the project processes, controls and reporting metrics that will be used to ensure the success of the project.

4.04.08 Approach to Implementation Phase – Tab 4

This section of the Bid Response shall clearly describe the Bidder's approach to some of the key issues that will impact the success of the AMMIS construction and

implementation efforts. **It is not sufficient for the Bidder to state that the Bidder intends to meet the requirements, and any such response to the requirements in this ITB will be considered non-responsive.** The focus of discussion in these areas should be on plans for this project, not on previous experience. The Agency wants to know how its objectives will be met, what assurances of success the proposed approach will provide, and what staff will support the Bidder's efforts, both on-site and at other locations during the Implementation Phase. The Agency wants the Bidder to identify the methods that will be used to ensure success for each phase of the project. The Agency is interested in the processes, reporting metrics, and contingency plans for ensuring an on time, fully functional implementation of the AMMIS.

The specific topics to be addressed in this section are:

- Design and Development Methodology
- Products and Deliverables
- Implementation Phase and Work Plan
- Proposed Staffing
- Implementation Phase Contract Management
- Commitment to Quality

4.04.08.01 Design and Development Methodology

In this section, the Bidder shall present the methodology to be used to complete *Section 2 - Statement of Work*. The Bidder shall:

1. Discuss the proposed design methodology for accomplishing this phase. Describe the formal approach to be followed, the major features of the proposed methodology and how this approach will best meet user objectives.

2. Discuss where the methodology has been used in the past (in other MMIS accounts), including an assessment of the results of the approach. The Bidder will define why this method was viewed as a success.

3. Discuss the Bidder's approach to conducting detailed requirements definition sessions for validating, documenting and refining requirements and how these definitions were used to complete the system design.

4. Describe the approach to systems analysis, design and testing for the external system interfaces. This includes any tools, process or procedures that will ensure the design fulfills the AMMIS requirements.

5. Describe the proposed approach to the construction and unit test phases. This includes any tools, processes or procedures that will be used to ensure the modifications meet the AMMIS requirements.

6. Describe the proposed approach to testing that will ensure all the required test tasks will be completed and will work together to thoroughly test the AMMIS and requested enhancements.

7. Describe the proposed approach to Quality Assurance (QA) that will ensure the Bidder submits the highest quality deliverables to the Agency.

4.04.08.02 Products and Deliverables

In this section, the Bidder shall present the products and deliverables of the proposed implementation methodology. The Bidder shall:

1. Identify the deliverables that will be produced, outline their contents, explain their purpose and relationship to the other deliverables, and demonstrate how they can be used to measure progress on the system construction and implementation effort. Provide examples of similar products as part of the discussion. Identify the project controls and metrics that will be used to measure the project progress and commitment to quality.

2. Describe the proposed approach for ensuring quality assurance on the products submitted. Define the QA processes, procedures, reporting metrics, quality thresholds and escalation procedures that will be used for the project.

4.04.08.03 Implementation Phase and Work Plan

In this section, the Bidder shall describe its approach to completing each of the ITB defined Implementation Phase tasks by presenting the Implementation Phase project work plan and schedule. The Bidder shall:

1. Present an Implementation Phase work breakdown structure for the Contract Start-Up and Planning; Requirements Definition; and System Analysis, Design and Specifications Tasks. A non-incumbent Bidder will provide the information below for the tasks defined in *Section 2.03 - Operations Implementation Phase (OIP) – Statement of Work.* The incumbent Bidder will provide the information below for the tasks defined in *Section 2.04 - Enhancement Implementation Phase (EIP) – Statement of Work.*

2. The work plan detail for these first three (3) tasks shall include the following:

    - A breakdown of all subtasks, activities, and sub-activities, including internal QA reviews, Agency review, Agency requested modifications and sign-off points.

- Calendar-based task schedules of the Implementation Phase showing estimated Agency and Vendor person-weeks of effort by labor category for each task and major subtask, both separately and totaled for each task.

- Gantt and PERT charts showing start and end dates for all tasks and subtasks and the relationship between tasks and subtasks.

- A schedule for submission and possible revision of all deliverables and their review by Agency staff; this schedule shall allow for revision and correction of Agency requested changes.

- Method for ensuring the project stays on schedule, including allowed deviation and recovery processes.

- Personnel and time-estimating procedures.

The remaining Implementation Phase tasks shall be defined at the subtask level. The work plan will be revised prior to the initiation of each task to provide sub-activity level of detail planning.

4.04.08.04 Proposed Staffing

This section details the Bidder's proposed staffing for the Implementation Phase. **It is expected that personnel proposed for the project will be committed and truly engaged with the project and that inexperienced personnel will not be exchanged for them. Should specific personnel proposed by the Bidder not be available, or if the Agency determines that key personnel are not providing an adequate amount of time on-site, the Agency reserves the right to cancel the project and all prior agreements with the Bidder or make appropriate adjustments to any work plan and prices to be paid here in under.** *Additionally, the Agency also reserves the right to impose liquidated damages of up to 10% of the total proposed project price should specific personnel proposed by the Bidder or Agency approved substitutions not be available, or become materially absent during the course of the project.* The Bidder shall:

1. Provide an organization chart for the overall Implementation Phase depicting staffing for each task, including numbers, labor categories, and the location where work will be performed.

2. Provide project team reporting relationships and authority of proposed key personnel.

3. Describe minimum qualifications for key personnel and their proposed roles and responsibilities.

4.04.08.05 Implementation Phase Contract Management

In this section, the Bidder shall discuss its approach to contract management. The Bidder shall:

1. Discuss proposed project management tools, including whether they are automated or manual.

2. Describe the Bidder's contingency plan. This description shall include how contingent support will be requested and delivered, and under what circumstances the plan will be executed.

3. Describe the Bidder's approach to quality management. Include a discussion of the features that will be used to protect the integrity and quality of work performed during the Implementation Phase.

4.04.09 Approach to Operations Phase – Tab 5

This section of the Bid Response shall clearly describe the Bidder's approach to some of the key issues that will impact the success of the AMMIS operations efforts. **It is not sufficient for the Bidder to state that the Bidder intends to meet the requirements, and any such response to the requirements in this ITB will be considered non-responsive.** The Agency wants to know how its objectives will be met, what assurances of success the proposed approach will provide, and what staff will support the Bidder's efforts, both on-site and at other locations during the Operations Phase. The Agency wants the Bidder to identify the methods that will be used to ensure success for the Operations phase of the project. The Agency is interested in the processes, reporting metrics, contingency plans and approach for ensuring successful operation of the AMMIS.

The specific topics to be addressed in this section are:

- Proposed Staffing

- Quality Assurance

- System Maintenance and Modification

4.04.09.01 Proposed Staffing

This section presents the Bidder's proposed staffing approach for the Operations Phase. The Bidder shall:

1. Provide an organization chart depicting staffing for all functional areas, including numbers, labor categories, reporting relationships, and location.

2. Provide an Operations Phase staffing approach by task and labor category, showing estimated hours for each category. The approach shall include the following:

    - Classification and number of personnel needed for each operational unit to include the minimum staffing levels in *Section 7.08 - Appendix H – Staffing Requirements*.

    - Job descriptions for all professional, managerial, and supervisory staff.

    - Minimum qualifications and general responsibilities for key personnel as specified in *Section 7.08 - Appendix H – Staffing Requirements*.

    - Limitations of authority of proposed key personnel.

3. Provide any contingencies or assumptions for changes in volume or level of effort included in the staffing approach.

4.04.09.02 Quality Assurance

In this section, the Bidder shall fully describe their approach to quality assurance (QA) and quality management for all aspects of the Operations Phase of the contract. The Bidder shall include in this response the proposed quality assurance approach for manual functions and system interfaces and performance monitoring tools for electronic claims processing functions, customer relations, and automated file inquiry features. The Bidder shall:

1. Define how QA will be proactive in reducing errors.

2. Define the QA process and procedures.

3. Define the proposed QA reporting metrics and the process to gather these metrics.

4. Define the QA error thresholds.

5. Define the QA escalation procedures.

4.04.09.03 System Maintenance and Modification

This section presents the Bidder's approach to meeting the Maintenance and Modification requirements. The Bidder shall:

1. Describe the proposed approach to system modification responsibilities which addresses:

    - Staffing levels proposed, including minimum qualifications, location, reporting relationship, or interfaces with the local Systems Manager.

- The role and responsibilities of the Systems Manager and minimum qualifications for this individual.

- Commitment to provide the hours requested as change requests are approved by the Agency.

- Proposed approach to coordinating on-site and off-site support.

- Proposed approach to ensuring progress on completion of change requests and tracking of work, priorities, and resources committed to change requests.

2. Describe the proposed approach to system maintenance.

Note: The Agency does not want to receive and will not consider a copy of detailed system documentation for proposed features or system components in conjunction with this response.

4.04.10 Corporate Capabilities and Commitments – Tab 6

In this section of the response, Bidders shall present material describing corporate capabilities to successfully perform this contract. Previous experience, current contractual obligations, and corporate resources, including personnel and information systems, will all be used to measure capability. Reference checks will be done.

The Corporate Capabilities section is limited to forty (40) pages, excluding financial statements. Graphs, charts, and tables presented by the Bidder in this section are included in the forty (40) page limit.

The specific topics to be included in this section are:

- Corporate Information

- Financial Statements

- Contractual Disputes

- Corporate Commitments

4.04.10.01 Corporate Information

In this section, the Bidder shall:

1. Include a description of the Bidder's corporation and each subcontractor's firm (if any). This discussion shall describe the structure, information system's background and resources (both equipment and personnel). Details shall include:

    - Name of Bidder

- Date established
- Ownership (public company, partnership, subsidiary, etc.)
- Location of office responsible for this contract
- Company contacts: the name, title, street address, city, state, zip code, email address, and telephone and fax number of the primary contact person for this contract
- Identification of any parent organization or subsidiaries
- Total number of employees in the corporation
- Profit or nonprofit status
- Number of personnel assigned to each of the following:
    - MMIS development
    - MMIS operations
    - Other claims processing, development, and operations
    - Computer system development
- Computer resources and the extent to which they are dedicated to other projects.

2. Describe how the Bidder will address any potential conflicts between current corporate contracts and the AMMIS project.

3. The Bidder shall provide the Agency the name and address of each person with an ownership or controlling interest in the Bidder's corporation or any subcontractor in which the Bidder's corporation has a direct or in-direct ownership interest of five percent (5%) or more. If this does not apply the Bidder shall provide a statement to that affect.

4. The Bidder shall disclose to the Agency whether any of the individuals identified in #3 above are related to one another as spouse, parent, child or sibling. If this does not apply the Bidder shall provide a statement to that affect.

5. The Bidder shall disclose the name of any other Fiscal Agent or provider which an individual named in #3 above has an ownership or controlling interest. If this does not apply the Bidder shall provide a statement to that affect.

4.04.10.02 Financial Statements

In this section, the Bidder shall demonstrate financial solvency and sufficient resources to handle any potential financial liability from outstanding lawsuits or judgments which could impact the Bidder's ability to continue to perform this contract. This section of the Bidder's response shall include:

1. Financial statements for the last three (3) completed fiscal years which shall include:

    - Income statements
    - Balance sheets
    - Statements of financial position
    - Notes to financial statements.

    If the Bidder is a subsidiary, the parent company shall be identified and financial statements from the parent company shall be submitted in addition to those of the subsidiary. The subsidiary shall secure a statement from the parent company that the parent company is able to cover the costs of implementation.

2. A statement indicating the percentage of total annual revenue represented by Fiscal Agent and MMIS installation contracts for the preceding three (3) fiscal years.

3. References to any parent company resources or other sources of income available to the Bidder organization.

4.04.10.03 Contractual Disputes

A list shall be submitted by the Bidder of any contractual disputes, penalties imposed, out of court settlement(s), liquidated damage(s), contract default(s), cancellation of contract(s) or components of contract(s) for cause, lawsuits/litigation (pending or past) within the last six (6) years related to MMIS or any claims processing or other operations or implementation including names of all parties, nature of the complaint, status or final disposition, and potential impact on the Alabama MMIS contract. This is in addition to the required information on the *Section 7.12 Appendix L – Business Experience Matrix*.

4.04.10.04 Corporate Commitments

The Bidder has the opportunity to present its corporate commitments to this contract in narrative format within this section.

4.04.11 Appendix – Tab 7

The *Section 7.12 Appendix L - Business Experience Matrix* shall be bound into the original volume and all copies of the Bid Response.

BID EVALUATION CRITERIA

5.01 Introduction

The objective of the bid evaluation process is to determine the bid which most cost effectively meets the Agency's goals and requirements of this ITB. A comprehensive, fair and impartial evaluation of bids received in response to this procurement effort will be conducted. All bids that meet the Division of Purchasing Administrative requirements shall start at Phase I of the bid evaluation process as indicated below. The apparent lowest bid as determined by the Division of Purchasing shall move forward in the bid evaluation process from Phase I to Phase II and progress through the bid evaluation phases based on meeting the evaluation criteria as applicable. A preselected bid evaluation team of Agency employees shall conduct bid evaluation Phase II, III and IV.

Bid evaluation criteria for Phase II and Phase III are defined in *Section 5.03 Bid Mandatory Requirements Evaluation* and *Section 5.04 Vendor Bid Evaluation Criteria*. The Agency's bid evaluation team shall use the evaluation criteria to qualify or disqualify a bid based on the evaluator's evaluation of the bid response. When a bid is disqualified by the evaluators it will be dropped from the bid evaluation process, the next apparent lowest Bidder's bid shall be selected, and the evaluation process shall start again at Phase II. The bid evaluation process shall continue until a bid is awarded or there are no more bids to consider.

The Division of Purchasing accepted bids shall be evaluated in the following four (4) phases:

- Phase I – Determining Apparent Lowest Fixed Total Price Bid (Finance Division of Purchasing);
- Phase II – Bid Mandatory Requirements Evaluation
- Phase III – Vendor Bid Evaluation Criteria
- Phase IV – ITB Award Recommendation.

The contract awarded under this ITB will be made to the responsible, responsive Bidder with the lowest fixed total price based on the ITB Award Recommendation made by the Alabama Medicaid Agency.

5.02 Phase I – Determining Apparent Lowest Fixed Total Price Bid

The Department of Finance, Division of Purchasing, shall determine the apparent lowest fixed total price bid based on the Bidders Bid Total price from the ITB Bid Sheet. Bids that are incomplete will be declared non-responsive and will be rejected with no further evaluation. Accepted bids shall be ordered from lowest to highest Bid Total price. Only the apparent lowest Bidder's bid shall move forward in the evaluation process to Phase II. In the event that the

apparent lowest bid fails to meet or pass the bid evaluation criteria in Phase II or III, the next apparent lowest bid shall be evaluated beginning at Phase II of the evaluation process.

5.03 Phase II –Bid Mandatory Requirements Evaluation

Upon receipt of proposals, the MMIS Coordinator and a State of Alabama's Department of Finance, Division of Purchasing staff representative (purchasing representative) will first examine each original bid response that passes Phase I for adherence to the initial submission requirements outlined in the table in *Section 5.03.01* below. Any response that would cause a bid to be disqualified on any item(s) will be referred to the Medicaid General Counsel for review and interpretation. Those bid response proposals found to be in compliance with the mandatory submission requirements in *Section 5.03.01* below will then be forwarded to the Evaluation Committee for a review of the Bidder's response against the requirements outlined in the ITB.

5.03.01 Phase II Mandatory Requirements Criteria

Bidder Response Checklist	**RESULTS**	
	Pass (Yes)	Fail (No)
GENERAL RESPONSE REQUIREMENTS (as defined in ITB Section 4.01) 1. Was the proposal received by the State of Alabama's Department of Finance, Division of Purchasing by the date and time specified in the ITB Section 1.05 - Schedule of Activities?		
2. Was a notarized State of Alabama "Invitation to Bid" form, signed in ink by the Bidder (or an officer of the Bidder who is legally authorized to bind the Bidder to the proposal) submitted as specified in ITB Section 1.10 - Bidder's Submission?		
3. Were one (1) original and ten (10) copies plus two (2) electronic versions of the proposal, with the Transmittal Letter, submitted with at least one (1) copy containing the required original signatures?		
4. Was a Letter of Intent to Bid submitted by the date and time as specified in ITB Section 1.05 - Schedule of Activities?		
5. Was a bid bond guarantee in the amount of three-hundred thousand dollars ($300,000) submitted in the original hard-copy version of the Bid Response, in the required format as specified in ITB Section 1.25 - Bid Guarantee?		

Bidder Response Checklist	RESULTS	
	Pass (Yes)	Fail (No)
BID RESPONSE REQUIREMENTS (as defined in ITB Section 4.04) 6. Does the Proposal include seven (7) separate sections and assorted subsections, as described in ITB Section 4.04.02: • Tab 1A - Transmittal Letter? • Tab 1B - Bid Guarantee (Original Volume Only)? • Tab 1C - State Invitation to Bid Form and Pricing Schedules Original Volume Only)? • Tab 2 - Table of Contents? • Tab 3 - Executive Summary? • Tab 4 - Approach to Implementation Phase? • Tab 5 - Operations Phase? • Tab 6 - Corporate Capabilities and Commitments? • Tab 7 - Appendix?		
7. Is the Transmittal Letter, on official business letterhead, from the entity submitting the proposal as the prime contractor?		
8. Is the Transmittal Letter signed by an individual authorized to legally bind the Bidder?		
9. Does the Transmittal Letter include a statement addressing each of the items in ITB Section 4.03 – Transmittal Letter numbers 1a-q?		
10. Does the Transmittal Letter include a completed and signed Disclosure Statement as identified in ITB Section 4.03 – Transmittal Letter number 1r? COMMENT:(If not, the Bidder will be given an opportunity to correct the deficiency)		
11. If subcontractors are proposed, has each subcontractor submitted a statement, on official letterhead, signed by an individual authorized to legally bind the subcontractor to perform the scope of work, and addressing each of the items in ITB Section 4.03 - Transmittal Letter numbers 2 a-e? If subcontractors are not proposed, was there a statement to that effect?		
12. Does the Transmittal Letter explicitly identify and explain where the proposal deviates, in any way whatsoever, from the detailed specifications and requirements in the ITB?		

Bidder Response Checklist	RESULTS	
	Pass (Yes)	Fail (No)
TABLE OF CONTENTS **(as defined in ITB Section 4.04.06)** 13. Is there a Table of Contents with the titles for each section and beginning page numbers?		
EXECUTIVE SUMMARY **(as defined in ITB Section 4.04.07)** 14. Is the Executive Summary no more than twenty-five (25) pages in length?		
APPROACH TO IMPLEMENTATION PHASE **(as defined in ITB Section 4.04.08)** 15. For each of the six (6) components identified in ITB Section 4.04.08, has the Bidder provided the required information in the order and format specified? • Design and Development Methodology • Products and Deliverables • Implementation Phase and Work Plan • Proposed Staffing • Implementation Phase Contract Management • Commitment to Quality		
APPROACH TO OPERATIONS PHASE **(as defined in ITB Section 4.04.09)** 16. Does the Bidder include a staffing approach for the operations phase?		
CORPORATE CAPABILITIES AND COMMITMENTS **(as defined in ITB Section 4.04.10)** 17. Is the Corporate Capabilities and Commitments section no more than forty (40) pages long, exclusive of financial statements? And does it contain Corporate Information, Financial Statements, Contractual Disputes and Corporate Commitments?		

Bidder Response Checklist	RESULTS	
	Pass (Yes)	Fail (No)
18. Did the Bidder complete Appendix L – Business Experience Matrix with a minimum of three (3) references of previous contracts in which the Bidder processed medical claims included in the proposal?		
19. Has the Bidder submitted financial statements?		
PRICING SCHEDULES (as defined in ITB Section 4.04.05) 20. Is there a signed and completed Pricing Schedule A(I) or A(N)?		
21. Is there a signed and completed Pricing Schedule B(I) or B(N)?		
22. Is there a signed and completed Pricing Schedule C(I) or C(N)?		
23. Is there a signed and completed Pricing Schedule D(I) or D(N)?		
24. Are all the calculations shown on the various pricing schedules accurate?		

5.04 Phase III – Vendor Bid Evaluation Criteria

Phase III of the bid evaluation process shall evaluate the Bidder's responses to the ITB based on the ITB requirements. Each bid evaluated must pass the bid evaluation criteria for this phase as documented in *Section 5.04.01* below. Bids that fail to pass the evaluation criteria of Phase III shall be disqualified from further evaluation. Any response that would cause a bid to be disqualified on any item(s) will be referred to the Medicaid General Counsel for review and interpretation. Bids that pass the bid evaluation criteria of Phase III shall move forward to Phase IV of the bid evaluation process.

5.04.01 Phase III Bid Evaluation Criteria

Each bid will be evaluated by the Evaluation Team to determine if the bid is sufficiently responsive to the ITB by reviewing details in *Section 4.04 - Bid Response* using a series of evaluation items. Each evaluator will rate the bid response for each item using a scale of 1 to 5.

Rating of 1 - very poor to unacceptable
Rating of 2 - poor
Rating of 3 - adequate
Rating of 4 - above average
Rating of 5 - excellent.

The scores of the reviewers for each rated item will be averaged. An average score of less than 3.00 on any item will result in that bid being disqualified from consideration.

Each bid evaluated by the Evaluation Team will be reviewed to determine if the bid is responsible by reviewing details in *Section 4.04.10 Corporate Capabilities and Commitments* of the ITB on a pass/fail basis. The Agency reserves the right to contact and conduct interviews with any previous customers of the Contractor and/or its sub-contractors.

Bids that do not meet the minimum requirements criteria shall be disqualified from further evaluation. Any response that is incomplete or in which there are significant inconsistencies or inaccuracies may be rejected by the Agency. The Agency reserves the right to waive minor variances or reject any or all bids. The Agency reserves the right to request clarifications from all Bidders.

5.05 Phase IV – ITB Award Recommendation

The ITB evaluation committee shall submit a written recommendation to the Commissioner to award the ITB to the Bidder that successfully makes it to this phase of the evaluation process. The Commissioner will make the final decision to award the contract based on the recommendations of the evaluation committee. The Agency shall notify the Division of Purchasing in writing about the bid selection. The Division of Purchasing will notify the successful Bidder after receiving the Agency's bid award recommendation. If the Bidder selected is unwilling or unable to perform, the bid bond will be forfeited and the Agency may award to the next lowest responsible and responsive Bidder most advantageous to the state.

5.06 Federal Approval

Federal approval is required before the Agency may award a contract. Every effort will be made by the Agency, both before and after selection, to facilitate the rapid approval and an early start date for the selected Vendor.

GENERAL TERMS AND CONDITIONS

6.01 General Contract Terms

6.01.01 Entire Agreement

This ITB and the Vendor's response thereto shall be incorporated into two (2) contracts by the execution of formal agreements, specimen copies of which are attached hereto in *Section 7.02 - Appendix B.* Any reference in this ITB or other documents to a singular contract shall be deemed to include both contracts, unless the context clearly indicates otherwise. No alteration or variation of the terms of these contracts shall be valid unless made in writing and duly signed by the parties thereto. Oral understandings of this agreement are not incorporated therein and no alterations or variations of the terms thereof shall be binding on any of the parties unless made in writing between the parties. These contracts shall be amended by written agreement duly executed by the parties; every such amendment shall specify the date of its provisions and shall be effective as agreed to by the parties. These contracts and amendments, if any, are subject to approval by the Department of Health and Human Services (hereinafter referred to as HHS) and the Governor of the State of Alabama.

Execution of the contract and posting of the performance bond shall authorize the Vendor to undertake performance of the contract and shall entitle Vendor to be reimbursed for costs incurred in such performance, subject to all terms and conditions of the contract.

6.01.02 Notice to Parties

Any notice to the Agency under these contracts shall be sufficient when mailed to the Commissioner of the Alabama Medicaid Agency, P. O. Box 5624, Montgomery, Alabama 36103-5624. Any notice to the Vendor shall be sufficient when mailed to the Vendor at the address given on the return receipt from this ITB or on the contract after signing. All notices shall be given by certified mail, return receipt requested.

6.01.03 Headings and Titles

Any headings or titles used to help identify any part of this ITB or any contract upon which it is based are for reference purposes only and shall not be deemed as controlling the interpretation or meaning of any provision of this ITB or any contract upon which it shall be based.

6.01.04 Compliance with Federal and State Requirements

The Vendor shall perform all services under these contracts in accordance with applicable federal and state statutes and regulations. The Agency retains full operational and administrative authority and responsibility over the Alabama Medicaid Program in accordance with the requirements of the federal statutes and regulations as the same shall

be amended from time to time including the Health Insurance Portability and Accountability Act of 1996. The Vendor will be considered a Business Associate of the Agency and will be required to sign a Medicaid Business Associate Addendum. (See sample in *Section 7.14 - Appendix N.)*

6.01.05 Term of Implementation Contract

The implementation agreement shall be effective upon execution by all necessary parties and shall proceed from contract award until the later of September 30, 2011 or the date the Agency determines the Vendor has completed all Statement of Work tasks and is prepared to fulfill all requirements in *Section 3 – Requirements*.

6.01.06 Term of Operational Contract

The operational contract shall be for seven (7) years beginning October 1, 2011, and ending September 30, 2018. The Vendor shall process claims transferred from the previous Vendor and those claims received after the Friday of the last check write prior to September 30, 2011, except for those claims remaining unpaid at the close of business on September 30, 2011. Such unpaid claims shall be transferred promptly to the Agency or another Vendor as designated in writing by the Agency.

6.01.07 Beginning Work Under Contracts

The Vendor acknowledges and understands that these contracts are not effective until they have received all requisite State approvals, and the Vendor shall not begin performing work under these contracts until notified to do so by the Agency. The Vendor is entitled to no compensation for work performed prior to the effective date of these contracts.

6.01.08 Contract Content and Other Priority Documents

The contracts shall include the following:

- Executed contract
- ITB, and any amendments thereto
- Vendor's response to the ITB
- The Agency's written responses to prospective Bidders' questions
- Vendor's clarifications as requested by the Agency during the evaluation process.

The contracts shall be construed in accordance with and in the order of the applicable provisions of:

- Title XIX of the Social Security Act, as amended, and regulations promulgated thereunder by HHS and any other applicable federal statutes and regulations
- The statutory and case law of the State of Alabama
- The Alabama State Plan for Medical Assistance under Title XIX of the Social Security Act, as amended
- The Alabama Medicaid Agency Administrative Code
- The Alabama Medicaid Provider Manual
- The Agency's written responses to prospective Bidders' questions
- Vendor's clarifications as requested by the Agency during the evaluation process.

6.01.09 Contract Amendments

These contracts shall be deemed to include all applicable provisions of the State Plan and of all state and federal laws and regulations applicable to the Alabama Medicaid Program, as they may be amended. In the event of any substantial change in such Plan, laws, or regulations, which materially affect the operation of the Alabama Medicaid Program, or the costs of administering such Program, either party, after written notice and before performance of any related work, may apply in writing to the other for an equitable adjustment in compensation caused by such material change. Payment for administrative expenses, which as determined by the Agency, exceed the scope of work as described in the ITB (for example material enhancements to the AMMIS not required to be performed by the maintenance and modification teams as described in the ITB and the Vendor's proposal) shall require amendment to these contracts specifying the scope of such services and the amount payable therefore. Such payment shall not exceed the lesser of documented cost or approved estimated cost, based on rates specified in *Section 7.07 – Appendix G - Pricing Schedules*.

6.01.10 Changes to the Statement of Work

During implementation and operation, if the Vendor considers that any written or oral communication, including any order, direction, instruction, interpretation, or determination, received from the MMIS Implementation Project Manager, Fiscal Agent Liaison Officer or any Alabama Medicaid agent or representative, or that any other act or omission of the Alabama Medicaid Agency, its agent or representative (an "Event") constitutes a change to the scope of the Statement of Work of this ITB but is not plainly identified, labeled, or titled as such, the Vendor shall advise the designated Agency contact person in writing within ten (10) business days of the Event and shall request written confirmation of the Event. The notice shall state:

- The nature and pertinent circumstances of the communication, act, or omission regarded as a change in scope of the Statement of Work by the Vendor

- The date of the communication, act, or omission, and the identification of each individual involved in such communication, act, or omission, listing his or her name and function

- The identification of the documents involved

- The substance of any oral communications

- The particular technical requirements or contract requirements regarded as changed

- The direct and foreseeable consequential effect of the communication, act, or omission regarded as a change to the scope of the Statement of Work, including the number of hours required from the staff to accomplish the change and the manner and sequence of performance or delivery of supplies or services, identifying which supplies or services are or shall be affected.

The Agency shall respond within ten (10) days of receipt of the Vendor's notice, either:

- To countermand the action or communications regarded as an Event

- To deny that the Event is a change in the scope of the Statement of Work

- To confirm that the Event is a change to the scope of the Statement of Work by issuance of a written notice, or

- If the information in the Vendor's notice is inadequate to permit a decision to be made, advise the Vendor as to what additional information is required and establish the date by which this information shall be furnished.

If the Vendor complies with any order, direction, interpretation, or determination, written or oral, without providing the notice, in accordance with this section, the Agency shall not be liable for any increased price, delay in performance, or contract nonconformance by the Vendor.

If the Vendor does not agree with the decision of the Agency designee, the Vendor has thirty (30) days to appeal the decision to the Commissioner of Medicaid.

For the purposes of ordering changes to the scope of the Statement of Work during Implementation, the term "MMIS Implementation Project Manager" shall not include any representative of the MMIS Implementation Project Manager, whether or not such representative is acting within the scope of his or her authority, except in those instances where the MMIS Implementation Project Manager has notified the Vendor in writing, citing the authority of this section, that a specified individual has the authority to order

changes to the scope of the Statement of Work, and a description of the exact scope and duration of the individual's authority.

For the purposes of ordering changes to the scope of the Statement of Work during Operations, the term "Fiscal Agent Liaison Officer" shall not include any representative of the Fiscal Agent Liaison Officer, whether or not such representative is acting within the scope of his or her authority, except in those instances where the Fiscal Agent Liaison Officer has notified the Vendor in writing, citing the authority of this section, that a specified individual has the authority to order changes to the scope of the Statement of Work, and a description of the exact scope and duration of the individual's authority.

6.01.11 Additions to Permanent Staff

Both the Vendor and the Agency must agree upon additions to contract-required staff or key personnel. The reimbursement of the staff cannot exceed the current Vendor rate being paid for equivalent staff.

6.01.12 Force Majeure

Neither party to this contract shall be responsible for delays or failures in performance resulting from acts beyond the control of such party. Such acts shall include but not be limited to: acts of God, strikes, riots, lock-outs, acts of war, epidemics, fire, earthquakes or other disasters.

6.01.13 Not a Debt of the State

It is agreed that the terms and commitments contained herein shall not be constituted as a debt of the State of Alabama in violation of Article 11, Section 213 of the Constitution of Alabama, 1901, as amended by Amendment 26. It is further agreed that if any provision of this contract shall contravene any statute or Constitutional provision or amendment, either now in effect or which may, during the course of these contracts, be enacted, then that conflicting provision in the contract shall be deemed null and void. The Vendor’s sole remedy for the settlement of any and all disputes arising under the terms of these contracts shall be limited to the filing of a claim with the Board of Adjustment for the State of Alabama.

6.01.14 Use of Federal Cost Principles

For any terms of these contracts which allow reimbursement for the cost of procuring goods, materials, supplies, equipment, or services, such procurement shall be made on a competitive basis (including the use of competitive bidding procedures) where practicable, and reimbursement for such cost under these contracts shall be in accordance with 48 CFR Parts 300 to 399. Further, if such reimbursement is to be made with funds derived wholly or partially from federal sources, such reimbursement shall be subject to Vendor's compliance with applicable federal procurement requirements, and the determination of costs shall be governed by federal cost principles.

6.01.15 Non-assignment

These contracts shall not be assigned without written consent of the Agency. Except under exceptional circumstances, no such consent shall be given.

6.01.16 Subcontracts

The Vendor may subcontract for any services necessary to the completion and maintenance of this contract and to the performance of its duties under this contract with advance written approval by the Agency of both the subcontracted function and the subcontractor. Subcontractors include those whose services shall be purchased or software licensed by the Vendor, and any business partnerships between the Vendor and others. Subcontractors shall demonstrate the capability to perform the function to be subcontracted at a level equal or superior to that of the Vendor. All subcontracts shall be in writing, with the subcontractor functions and duties clearly identified, and shall require the subcontractor to comply with all applicable provisions of this ITB. The Vendor shall at all times remain responsible for the performance by any subcontractors approved by the Agency. The Vendor's performance bond and Vendor's responsibility for damages shall apply whether performance or nonperformance was by the Vendor or one of its subcontractors. The Agency shall not release the Vendor from any claims or defaults of this contract which are predicated upon any action or inaction or default by any subcontractor of the Vendor, even if such subcontractor was approved by the Agency as provided above. The Vendor shall give the Agency notice in writing by certified or registered mail of any action or suit filed against it by any subcontractor and prompt notice of any claim made against the Vendor by any subcontractor or vendor, which in the opinion of the Vendor may result in litigation related in any way to this contract with the State of Alabama.

6.01.17 State Ownership

The State of Alabama shall have all rights of ownership in software, any modifications thereof and all associated documentation designed, developed or enhanced by the Vendor for the AMMIS in the performance of its duties under this agreement. The Vendor shall obtain for the Agency any necessary licenses for all commercial or proprietary software not owned by the Vendor that is necessary for the performance of the duties and obligations expressed in this agreement. HHS reserves a royalty-free, nonexclusive and irrevocable license to reproduce, publish, or otherwise use, and authorize others to do so, such software, modifications, and documentation.

6.01.18 Firm and Fixed Price (Refer to 1.18 Proposal Prices)

6.01.19 Contractor not Entitled to Merit System Benefits

Under no circumstances shall the Contractor be entitled to receive the benefits guaranteed to state employees under the Merit System Act.

6.01.20 Conservation of Resources

To the extent practicable and economically feasible, the Vendor shall utilize products and services that conserve natural resources and protect the environment and are energy efficient.

6.02 Termination

6.02.01 Termination for Bankruptcy

The filing of a petition for voluntary or involuntary bankruptcy or a company or corporate reorganization pursuant to the Bankruptcy Act shall, at the option of the Agency, constitute default by the Vendor effective the date of such filing. The Vendor shall inform the Agency of any such action(s) immediately upon occurrence by the most expeditious means possible (i.e. telephone, fax, Federal Express, regular mail, etc.).

6.02.02 Termination for Default

The Agency may, by written notice, terminate performance under these contracts, in whole or in part, for failure of the Vendor to perform any of the material contract provisions. In the event the Vendor defaults in the performance of any of the Vendor's material duties and obligations, written notice shall be given to the Vendor specifying default. A copy of the written notice shall be sent to the Surety for the Vendor's Performance Bond.

The Vendor shall have thirty (30) calendar days, or such additional time as agreed to in writing by the Agency, after the mailing of such notice to cure any default. In the event the Vendor does not cure a default within thirty (30) calendar days, or such additional time allowed by the Agency, the Agency at its option may notify the Vendor in writing that performance under the contract is terminated and proceed to seek appropriate relief from the Vendor and Surety. If it is determined, after notice of termination for default, that the Vendor's failure was due to causes beyond the control of and without error or negligence of the Vendor, the termination shall be deemed a termination for convenience under *Section 6.02.04*.

6.02.03 Termination for Unavailability of Funds

Performance by the State of Alabama of any of its obligations under these contracts is subject to and contingent upon the availability of state and federal monies lawfully applicable for such purposes. If the State of Alabama, in its sole discretion, deems at any time during the term of these contracts that adequate monies lawfully applicable to this agreement shall not be available for the remainder of the term, the Agency shall promptly notify the Vendor to that effect, whereupon the obligations of the parties hereto shall end as of the date of the receipt of such notice and the contract shall at such time be canceled without penalty to the State of Alabama or the Federal Government.

6.02.04 Termination for Convenience

The Agency may terminate performance of work under the Contract in whole or in part whenever, for any reason, the Agency, in its sole discretion determines that such termination is in the best interest of the State. In the event that the Agency elects to terminate the contract pursuant to this provision, it shall so notify the Vendor by certified or registered mail, return receipt requested. The termination shall be effective as of the date specified in the notice. In such event, the Vendor will be entitled only to payment for all work satisfactorily completed and for reasonable, documented costs incurred in good faith for work in progress. The Vendor will not be entitled to payment for uncompleted work, or for anticipated profit, unabsorbed overhead, or any other costs.

6.03 The Vendor's Duties Upon Expiration/Termination

6.03.01 Procedure for Termination

Prior to the conclusion of these contracts, the Vendor shall provide, at no extra charge, full support and assistance in turning over the complete and current AMMIS to the Agency or its agent. The Agency desires a low-risk turnover that is transparent to recipients, providers, and users. Specific objectives are to provide for an orderly, complete, and controlled transition to a successor Vendor; and to minimize any disruption of processing and services provided to recipients, providers, and operational users of the system.

The Vendor must:

- Stop work under these contracts on the date and to the extent specified in the notice of termination.

- Place no further orders or subcontracts for materials or services, except as may be necessary for completion of such portion of work under these contracts as is not terminated.

- Terminate all orders and subcontracts to the extent that they relate to the performance of work terminated by the notice of termination.

- Assign to the Agency, in the manner and to the extent directed by the Agency, all of the rights, title, and interest of the Vendor under the orders or subcontracts so terminated, in which case the Agency shall have the right, in its discretion, to settle, pay or deny any or all claims arising out of the termination of such orders and subcontracts.

- With the prior approval or ratification of the Agency settle all outstanding liabilities and all claims arising out of such termination of orders and subcontracts, the cost of which would be reimbursable in whole or in part, in accordance with the provisions

of these contracts. Failure to obtain prior approval shall result in loss of the Agency reimbursement.

- Complete the performance of such part of the work as shall not have been terminated by the notice of termination.

- Take such action as shall be necessary, or as the Agency shall direct, for the protection and preservation of any and all property or information related to these contracts which is in the possession of the Vendor and in which the Agency has or shall acquire an interest.

- Upon Agency direction the Vendor shall change the disposition of pending claims transactions to deny.

6.03.02 Delivery of AMMIS

Approximately nine (9) months prior to expiration or upon termination of the contract, on a schedule and in a manner specified by the Agency, the Vendor shall deliver to the Agency, for no additional compensation, those *AMMIS deliverables listed in Section 7.11 Appendix K* plus all enhancements added during the contract and all data entry software. All deliverables shall reflect the then current operational system. Failure to deliver the required items under these provisions shall constitute default.

6.03.03 Transfer of Documents

At the Agency's discretion, but no later than three (3) days following expiration or termination of the contract, the Vendor, at its expense, shall box, label, and make readily accessible in the Vendor's Montgomery facility, the following items:

- All unprocessed original claims (sorted by claim type and clearly labeled), both paper and electronic media in the format in which they were submitted.

- All unprocessed refunds and adjustments (including all supporting documentation and correspondence organized in such a way as to allow easy identification of corresponding original claims).

- All original claims in pending status with applicable worksheets.

- All provider enrollment contracts and agreements and all pending provider enrollment requests/changes.

- Correspondence.

- All other unprocessed transactions and/or documents.

In the event that the last financial cycle of the contract period is more than one (1) week from the end of the contract period, all of these items shall be made available weekly.

6.03.04 Change of Address

The Vendor shall no later than the last postal business day of the contract submit to the United States Postal Service a standard change of address form indicating the new mailing address supplied to it by the successor Vendor. A change of address shall be turned in for each street address, post office box, or post office drawer used for receiving delivery of Medicaid claim forms and correspondence.

6.03.05 Dialogue

The Vendor shall at any time during the transition period and for a period no less than sixty (60) calendar days after expiration of the contract, answer all questions and provide any dialogue and training that the Agency in its sole discretion deems necessary to enable the successor Vendor to take over the system. All such communications shall be with or through the Agency's Fiscal Agent Liaison Officer or designee.

6.03.06 Post-Turnover Activities

In order to provide post-turnover support, the Vendor shall provide, at no charge to the Agency, the services of an on-site senior systems analyst and a senior programmer/analyst each of who have worked on the AMMIS for at least one (1) year. These two (2) individuals are required to be on-site for the ninety (90) calendar days following contract termination. The individuals proposed by the Vendor must be approved by the Agency. The Agency shall provide working space for these individuals and shall retain the authority to prioritize their responsibilities on a full-time basis to support post-turnover activity.

The Vendor shall also be responsible for, and must correct at no cost, any malfunctions that existed in the system prior to turnover or which were caused by lack of support at turnover, as shall be determined by the Agency within six (6) months following the turnover of operations.

6.03.07 Financial Closeout

Effective ninety (90) calendar days before contract expiration or upon notice of termination, the Vendor shall have all checks issued to providers printed with the statement "VOID AFTER 30 DAYS." All Medicaid bank accounts created under this contract shall be closed and all funds remitted to the Agency no later than sixty (60) calendar days following expiration or termination of the contract. The Agency shall be responsible for replacement checks. All financial records shall remain readily accessible in the Montgomery facility until completion of the bank account closeout and any accompanying audit of the Vendor’s financial records. Within sixty (60) calendar days

after expiration or termination of the contract, the Vendor shall provide an imaged copy of all canceled Medicaid provider checks that have not been furnished previously.

6.03.08 Maintenance of Software

The Vendor shall maintain all software and production data files used in the performance of the contract for at least one hundred twenty (120) calendar days after the expiration or termination of the contract and shall maintain such at a readily accessible place and shall make them available to the Agency on demand in the format and media requested.

6.03.09 Facilities and Equipment

Office space, as specified in *Section 2.02.02.04 – Location and Facility Requirements*, for Agency personnel, shall remain available until expiration or termination of the contract. The physical relocation of Agency staff from the Vendor's facilities to the successor's facilities shall be the sole responsibility of the Agency. Any computer equipment or software provided by the Vendor to the Agency under this agreement that is not the property of the Agency shall remain in operation until expiration or termination of the contract, or any extension thereof.

6.04 Employment

6.04.01 Non-Discrimination Compliance

The Vendor shall comply with Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, Executive Order No. 11246, as amended by Executive Order No. 11375, both issued by the President of the United States, the Americans with Disabilities Act of 1990, and with all applicable federal and state laws, rules and regulations implementing the foregoing statutes with respect to nondiscrimination in employment. The Vendor shall not discriminate against any employee or applicant for employment because of a physical or mental disability in regard to any position for which the employee or applicant is qualified. The Vendor agrees to take affirmative action to employ, advance in employment, and otherwise treat qualified disabled individuals without discrimination based on their physical or mental disability in all employment practices.

6.04.02 Small Businesses, Minority-Owned Firms and Women's Business Enterprises Utilization

In accordance with the provisions of 45 CFR Part 74 and OMB Circular A-102, affirmative steps shall be taken to assure that small businesses, minority-owned firms and women's business enterprises are utilized when possible as sources of supplies, equipment, construction, and services.

6.04.03 Worker's Compensation

The Vendor must take out and maintain during the initial term of these contracts and any renewal thereof, worker's compensation insurance for all of its employees working as part of this Contract; and, in the event any work is subcontracted, the Vendor must require any subcontractor similarly to provide worker's compensation insurance for all the latter's employees working as a part of this Contract.

6.04.04 Other Insurance

The Vendor must obtain, pay for and keep in force the following minimum insurance coverage and shall furnish a certificate to the Agency evidencing that such insurance is in effect:

- Comprehensive general liability policy with endorsement to insure contractual liability, personal injury, personal and advertising liability waiving right of subrogation against the State,

- Liability insurance against bodily injury or death of any one person in any one accident in the amount of five hundred thousand dollars ($500,000) and in the amount of one million dollars ($1,000,000) for the injury or death of more than one person in any accident; and

- Insurance against liability for property damages in the amount of one hundred thousand dollars ($100,000).

It shall be the responsibility of the Vendor to require any subcontractor to secure the same insurance coverage as prescribed herein for the Vendor, and to furnish to the Agency a certificate or certificates evidencing that such insurance is in effect. Evidence of insurability under these provisions shall be directed to the Agency. In addition, the Vendor must indemnify and save the State harmless from any liability arising out of the Vendor's or any subcontractor's untimely failure in securing adequate insurance coverage as prescribed herein. All such coverage shall remain in full force and effect during the initial term of these contracts and any renewal thereof.

6.04.05 Employment of State Staff

The Vendor shall not knowingly engage on a full-time, part-time, or other basis during the period of these contracts, any professional or technical personnel who are or have been in the employ of the Agency during the previous twelve (12) months, except regularly retired employees, without the written consent of the Agency. Certain Agency employees may be subject to more stringent employment restrictions under the Alabama Code of Ethics, §36-25-1, et seq., Code of Alabama 1975.

6.04.06 Provision of Gratuities

Neither the Vendor nor any person, firm or corporation employed by the Vendor in the performance of these contracts shall offer or give, directly or indirectly, to any employee or agent of the State, any gift, money or anything of value, or any promise, obligation or contract for future reward or compensation at any time during the term of these contracts.

6.05 Guarantees, Warranties, and Certifications

6.05.01 Security and Release of Information

The Vendor shall take all reasonable precautions to ensure the safety and security of all information, data, procedures, methods, and funds involved in the performance under these contracts, and shall require the same from all employees so involved. In compliance with 42 CFR §431.300 et seq., the Vendor shall conform to the requirements of federal and state regulations regarding confidentiality of information about eligible recipients. The Vendor shall not release any data or other information relating to the Alabama Medicaid Program without prior written consent of the Agency. This provision covers both general summary data as well as detailed, specific data. The Vendor shall not be entitled to use of Alabama Medicaid Program data in its other business dealings without prior written consent of the Agency. All requests for program data shall be referred to the Agency for response by the Commissioner only. Unauthorized use of information shall be subject to the imposition of liquidated damages in the amount of twenty thousand dollars ($20,000.00) per occurrence.

6.05.02 Federal Nondisclosure Requirements

Each officer or employee of any person to whom Social Security information is or may be disclosed shall be notified in writing by such person that Social Security information disclosed to such officer or employee can be only used for authorized purposes and to that extent and any other unauthorized use herein constitutes a felony punishable upon conviction by a fine of as much as five thousand dollars ($5,000) or imprisonment for as long as five (5) years, or both, together with the cost of prosecution. Such person shall also notify each such officer or employee that any such unauthorized further disclosure of Social Security information may also result in an award of civil damages against the officer or employee in an amount not less than one thousand dollars ($1,000) with respect to each instance of unauthorized disclosure. These penalties are prescribed by IRC Sections 7213 and 7431 and set forth at 26 CFR 301.6103(n).

Additionally, it is incumbent upon the Vendor to inform its officers and employees of penalties for improper disclosure implied by the Privacy Act of 1974, 5 USC 552a. Specifically, 5 USC 552a (1) (1), which is made applicable to the Vendors by 5 USC 552a (m) (1), provides that any officer or employee of the Vendor who, by virtue of his/her employment or official position, has possession of or access to Agency records which contain individually identifiable information, the disclosure of which is prohibited by the Privacy Act or regulations established thereunder, and who knowing that

disclosure of the specific material is prohibited, willfully discloses that material in any manner to any person or agency not entitled to receive it, shall be guilty of a misdemeanor and fined not more than five thousand dollars ($5,000).

6.05.03 Health Insurance Portability and Accountability Act of 1996 Requirements

All parties shall comply with the provisions of the Health Insurance Portability and Accountability Act of 1996 and any implementing regulations as adopted.

6.05.04 Share of Contract

No official or employee of the State of Alabama shall be permitted any share of these contracts or any benefit that may arise therefrom.

6.05.05 Conflict of Interest

The Vendor covenants that it presently has no interest and shall not acquire any interest, direct or indirect, which would conflict in any manner or degree with the performance of its services hereunder. The Vendor further covenants that in the performance of these contracts no person having any such known interests shall be employed by the Vendor.

6.05.06 Debarment

The Vendor certifies that neither it nor its principals is presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from participation in this contract by any federal department or agency.

6.05.07 Performance Bond

In accordance with the provisions of Code of Alabama, 1975, Section 41-16-28, a performance bond in the amount of ten million dollars ($10,000,000) with a corporate bonding company satisfactory to the Agency as Surety shall be posted by the Vendor at the time of execution of these contracts. This bond shall be in force from that date through the term of the operations contract and ninety (90) calendar days beyond and shall be conditioned on faithful performance of all contractual obligations. Failure of the Vendor to perform satisfactorily shall cause the performance bond to become due and payable to the State of Alabama. The State of Alabama, Department of Finance, Director of Purchasing shall be custodian of the performance bond. Said bond shall be extended in the event the Agency exercises its option to extend the operational contract. An irrevocable letter of credit acceptable to the State shall meet this provision.

6.05.08 Indemnification

The Vendor agrees to indemnify, defend and hold harmless the State, the Agency, and their officers, agents and employees (hereinafter collectively referred to as

"indemnitees"), for all claims, losses, or suits accruing or resulting from the Vendor's performance or non-performance of its duties under these contracts. The Vendor, at its own expense, shall defend any claim or suit which may be brought against the State for the infringement of any patents, copyrights, proprietary rights or right of privacy arising from the Vendor's or State's use of any equipment, materials, or information prepared or developed in conjunction with performance of these contracts. The Vendor shall, in any such suit, satisfy any final judgment for infringement. Any federal sanction or damages, other than those specified herein, imposed upon the State due to the Vendor's failure to perform its responsibilities under these contracts shall be paid by the Vendor.

The Vendor hereby waives, releases, relinquishes, discharges and agrees to indemnify, protect and hold harmless the indemnitees of and from any and all claims, demands, liabilities, loss, costs or expenses for any loss or damage, (including but not limited to bodily injury or personal injury including death, property damage, workers' compensation benefits, employment benefits, libel, slander, defamation of character and invasion of privacy) and attorney fees, caused by, growing out of, or otherwise happening in connection with these contracts, due to any act or omission (whether intentional or negligent, through theft or otherwise), or due to any breach of this contract, or due to the application or violation of any pertinent federal, state or local law, rule, policy or regulation by the Vendor.

This indemnification applies whether: (1) the activities involve third parties or employees, subcontractors or agents of the Vendor or indemnitees; or (2) a claim results in a monetary obligation that exceeds any contractual commitment.

This indemnification extends to the successors and assigns of the Vendor, and this indemnification and release survives the termination of this contract and the dissolution or, to the extent allowed by law, the bankruptcy of the Vendor.

The Vendor must, at its expense, be entitled to and shall have the duty to participate in the defense of any suit against the indemnitees. No settlement or compromise of any claim, loss or damage asserted against indemnitees shall be binding upon the indemnitees unless expressly approved by the indemnitees.

6.05.09 Compliance with Environmental Standards

The Vendor agrees to comply with all applicable standards, orders or regulations issued pursuant to the Clean Air Act, 42 U.S.C. 7401 et seq. and the Federal Water Pollution Control Act, as amended 33 U.S.C. 1251 et seq., Executive Order 11738, and other Environmental Protection Agency regulations.

6.05.10 Waiver

No covenant, condition, duty, obligation, or undertaking contained in or made a part of these contracts shall be waived except by written agreement of the parties expressly acknowledging this waiver as a modification of the contracts.

6.05.11 Warranties Against Broker's Fees

The Vendor warrants that no person or selling agency has been employed or retained to solicit or secure these contracts upon an agreement or understanding for a commission, percentage, brokerage, or contingent fee except bona fide employees. For breach of this warranty, the Agency shall have the right to terminate these contracts without liability to the Agency.

6.05.12 Novation

In the event of a change in the corporate or company ownership of the Vendor, the Agency may, subject to approval by HHS and a determination by the Agency that the successor can meet the needs of the Agency, recognize the successor's interest in the transfer of these contracts. The new corporate or company entity shall agree to the terms of the original Contract and any amendments thereto. During the interim between legal recognition of the new entity and the Agency execution of the novation agreement, valid contracts shall continue to exist between the Agency and the original Vendor. When, to the Agency's satisfaction, sufficient assets necessary for the performance of these contracts have been transferred from the original Vendor, the Agency shall approve the novation agreement.

6.06 Disputes and Litigation

6.06.01 Attorneys' Fees

In the event that the State shall prevail in any legal action arising out of the performance or non-performance of this Contract, the Vendor must pay, in addition to any damages, all expenses of such action including reasonable attorneys' fees and costs. This requirement applies regardless of whether the Agency is represented by staff counsel or outside counsel. Fees and costs of defense shall be deemed to include administrative proceedings of all kinds, as well as all actions at law or equity.

6.06.02 Disputes

Except in those cases where the bid response exceeds the requirements of the ITB, any conflict between the bid response of the Vendor and the ITB shall be controlled by the provisions of the ITB. Any dispute concerning a question of fact arising under these contracts which are not disposed of by agreement shall be decided by the Commissioner of Medicaid.

The Vendor's sole remedy for the settlement of any and all disputes arising under the terms of this agreement concerning compensation claimed to be due and payable to the Vendor, or any aspect of the performance of duties by the Vendor shall be limited to the filing of a claim with the Board of Adjustment for the State of Alabama. Pending a final decision of a dispute hereunder, the Vendor must proceed diligently with the performance of these contracts in accordance with the disputed decision.

For any and all disputes arising under the terms of this contract, the parties hereto agree, in compliance with the recommendations of the Governor and Attorney General, when considering settlement of such disputes, to utilize appropriate forms of non-binding alternative dispute resolution including, but not limited to, mediation by and through the Attorney General's Office of Administrative Hearings or where appropriate, private mediators.

6.06.03 Litigation

Any litigation brought by the Agency or the Vendor regarding any provision of these Contracts shall be brought in either the Circuit Court of Montgomery County, Alabama, or the United States District Court for the Middle District of Alabama, Northern Division, according to the jurisdictions of these courts. This provision is not intended to, nor shall it operate to, enlarge the jurisdiction of either of said courts, but is merely an agreement and stipulation as to venue.

6.07 Key Personnel and Contract Required Personnel

6.07.01 Key Personnel

The Vendor shall have the following key personnel located within the Vendor's facilities in Montgomery, Alabama:

1. Account Manager - Person responsible for the direction of all aspects of the operation. This person shall serve as the primary liaison to the Agency. For the duration of these Contracts, unless authorized by the Agency, the Vendor shall not relocate or divert in a direct or contingent manner to another contract the person approved by the Agency as the Account Manager.

2. Operations/Claims Processing Manager - Person responsible for claims receipt, data entry, claims resolutions, adjustments, and all other claims processing related functions.

3. Customer Relations Manager for Provider Relations - Person responsible for supervising provider enrollment, the customer relations staff and provider representatives.

4. AMMIS Systems Manager-Person responsible for maintenance of the AMMIS, coordination of the design, testing, and implementation of system enhancements, and supervision of the AMMIS Maintenance and Modification Teams.

5. AMMIS Implementation Manager - Person responsible for coordination of implementation activities.

The Agency shall have the absolute right to approve or disapprove the Vendor's and any subcontractor's key personnel assigned to these Contracts, to approve or disapprove any proposed changes in key personnel, or to require the removal or reassignment of any key personnel found unacceptable by the Agency. The Vendor shall notify the Agency's Fiscal Agent Liaison Officer in writing of any proposed change in key personnel at least thirty (30) calendar days prior to the change. No Vendor initiated change in key personnel shall be approved until a replacement has been approved by the Agency and is on site.

6.07.02 Contract-Required Personnel

The Vendor shall have the following contract-required personnel located within the Vendor's facilities in Montgomery: all key personnel, Quality Assurance Manager, Customer Relations Staff, SURS Analyst, TCM Prior Authorization Coordinator, HCPCS Coordinator, Medical Policy Specialist, Drug Data Warehouse Coordinator, EIS/DSS Technical Support, Provider Quality Assurance Evaluator, Medical Policy Analyst - Register Nurse with certification as a Certified Professional Coder, Medical Policy Analyst with certification as Certified Professional Coder, Systems/Technical Support and the Modification Team Members. A maximum of ten percent (10%) of the modification programming team may be located off the Vendor's Montgomery site unless otherwise approved by the Agency. This arrangement may be allowed as long as production capacity is not compromised and the hours and projects completed by the off-site programmers are documented by time sheets and projects worked on are adequately identified to the Agency. The Agency may require the Vendor to reduce or increase the percentage of the staff located off-site at its discretion. The Agency reserves the right to require a reduction in contract-required staff if during the term of the contract, it is determined that required functions could be performed by fewer than the specified number of individuals.

No diversion of contract-required personnel shall be made by the Vendor without prior written consent of the Agency. The Vendor shall have forty-five (45) calendar days in which to fill vacancies of contract-required personnel with another employee of acceptable technical experience and skills subject to prior written approval of the Agency, such approval not to be unreasonably withheld. The Vendor shall at all times maintain the performance standards and meet all functional requirements of the Contracts.

6.07.03 Other Personnel Requirements

The Vendor shall upon request provide the Agency with a resume of any members of its staff or a subcontractor's staff assigned to or proposed to be assigned to any aspect of the performance of these Contracts. Personnel commitments made on the Vendor's response shall not be changed except as herein provided or due to the resignation of any named individual.

6.08 Records

6.08.01 Records Retention and Storage

In accordance with 45 CFR §74.53, the Vendor shall maintain financial records, supporting documents, statistical records, and all other records pertinent to the Alabama Medicaid Program for a period of three (3) years from the date of the final payment made by the Agency to the Vendor under these Contracts. However, if audit, litigation, or other legal action by or on behalf of the state or federal government has begun but is not completed at the end of the three (3) year period, or if audit findings, litigation, or other legal action have not been resolved at the end of the three (3) year period, the records shall be retained until resolution. Subsequent to the contract term, documents shall be stored in a bonded storage facility accessible to the Agency during normal business hours.

6.08.02 Inspection of Records

The Vendor agrees that representatives of the Comptroller General, HHS, the General Accounting Office, the State of Alabama Department of Examiners of Public Accounts, the Agency and their authorized representatives shall have the right during business hours to inspect and copy the Vendor's books and records pertaining to contract performance and costs thereof. The Vendor shall cooperate fully with requests from any of the agencies listed above and shall furnish free of charge copies of all requested records. The Vendor may require that a receipt be given for any original record removed from the Vendor's premises.

6.08.03 Imaging Requirements

The Vendor shall submit to the Agency no later than sixty (60) days after contract signing, an imaging plan for approval. The Vendor shall provide the Agency with legible imaged copies on COLD or CD/DVD as specified for the following source documents:

- Claims daily on COLD
- EMC facsimiles daily on COLD
- Remittance advices within one business day of each financial cycle on COLD
- Canceled provider checks, front and back, monthly on CD/DVD
- Provider or State initiated adjustment requests daily on COLD
- Other documents as specified in this ITB.

Imaged copies on COLD or CD/DVD must be verified by the Vendor for quality. A verification report with samples must be provided to the Agency monthly. The original

source document must be retained on-site at the Vendor facility for ninety (90) calendar days after the date of receipt. The Agency reserves the right to reject any imaged copies of source documents if illegible. The Vendor shall correct illegible copies on COLD or CD/DVD within ten (10) days.

6.08.04 System Documentation

The Vendor shall establish and utilize documentation update procedures, including status report meetings with the Agency, to ensure that the AMMIS documentation remains current at all times. The Vendor shall maintain the master copy of all AMMIS documentation and shall furnish the Agency with one (1) complete copy by start of operations, and one (1) copy of each update. The Vendor shall provide the Agency's MMIS Coordinator's Office with a complete copy of all system documentation (e.g. all information maintained in iTRACE, detailed system designs, Data Element Dictionary, systems manuals, user manuals, provider manuals) on CD/DVD by the first Thursday of each month and shall remain consistent with the format of existing documentation. The Vendor shall incorporate any requirement change into all necessary documentation within five (5) days of implementation. The Vendor shall maintain and update monthly the Data Element Dictionary. In October of each year, the Vendor shall supply the Agency with a complete copy of all AMMIS software. The Vendor will also be required to provide a copy of all AMMIS software and systems documentation (in hard copy or electronic format) on request with advance notice.

6.09 Method of Payment and Invoicing

6.09.01 Payment

Payments are dependent upon successful completion and acceptance of described work and delivery of required documentation. Payment for the Vendor services shall be made according to the following provisions:

6.09.01.01 Implementation Phase Payments

The Agency shall provide payment to the Vendor in accordance with the State Purchasing Vendor's bid sheet and the *Section 7.07 – Appendix G - Pricing Schedules* for the MMIS Implementation Phase of this ITB. Payment shall be made monthly for the Agency deliverables accepted and approved (as specified in *Section 7.07 – Appendix G - Pricing Schedules*). The Vendor shall submit invoices to the Agency's MMIS Coordinator on a monthly basis for approved services and deliverables rendered to the Agency in the previous month. Each monthly invoice shall have a cover letter/memo addressed to the Agency's MMIS Coordinator printed on the Vendor's company letterhead. Attached to the Vendor's letter/memo shall be the Vendor's invoice. The invoice shall contain summary level descriptions of each invoiced line item.

6.09.01.02 Operational Costs

The firm and fixed prices for the operational activities not identified as pass-through expenses are reflected on *Section 7.07 – Appendix G - Pricing Schedules*. Compensation for the firm and fixed prices as stated in the Vendor's bid shall be due and payable to the Vendor upon submission to the Agency of a claims payment invoice on a monthly basis, subject to availability of funds. Each monthly invoice shall have a cover letter/memo addressed to the Agency's Fiscal Agent Liaison printed on the Vendor's company letterhead.

6.09.01.03 Definition of a Claim

The following is the definition of a claim, subject to the qualifiers also noted, for the purpose of claim volume accounting. This definition shall apply to administrative claims processing adjudication counts tracked and reported by the Vendor:

- Institutional Claims (UB-04) - A claim is a paper document or an EMC record requesting payment for services rendered during a statement period or date range for which there are one or more accommodation, HCPCS, and/or ancillary codes. This definition includes Part A Medicare crossover claims and encounter claims.

- Pharmacy Claims - A claim is each detail line item of a paper document or an EMC record requesting payment of a specific NDC code rendered to a recipient by the billing provider. This definition includes encounter claims.

- Managed Care Capitation and Case Management Payments - A claim is one payment to a PMP, Lock-In Provider or HMO for all the beneficiaries the provider is responsible for in a given month for a category of beneficiaries.

- All Other Claim Types - A claim is a detail line item on a paper document or an EMC record requesting payment for services rendered to a recipient by a provider on one or more service date(s) for which there is a HCPCS code. This definition includes Part B Medicare crossover claims and encounter claims.

Adjustments to paid claims are not countable as claims, regardless of the number of adjustments made to a paid claim or the reason for the adjustments.

All claims which require reprocessing due to errors caused by the Vendor in processing or due to system design shall not be included in any claims count.

No transaction shall be counted as a claim which does not meet the specific criteria stated above. Only claims adjudicated by the system for payment or denial shall be counted.

6.09.01.04 Pass-through Expenses

Compensation for all approved pass-through expenses shall be paid based on documented costs. The following as specified in this ITB shall be allowable pass-through expenses:

- All postage expenses directly related to the operation of the Contract, including postal preparation fees for bulk and mass mailings,

- Agency-approved printing of manuals, handbooks, and bulletins, as defined in *Section 3 – Requirements: 3.02.093, 3.02.094, 3.02.095, 3.02.096, and 3.02.098* (excluding enrollment packages), *3.02.099 - Provider Requirements*; *3.04.037, 3.04.038, and 3.04.039 - Reference Requirements* ; *3.12.011* (PCCM Provider Referral Report), *3.12.014, 3.12.016, 3.12.027, 3.12.028 - Managed Care Requirements*.

- Toll-free telecommunication lines, as defined in *Section 3- Requirements: 3.01.010 (dial up toll free line) - General Requirements, 3.02.135- Provider Requirements*; *3.06.002, 3.06.010, 3.06.049 - Claims Requirements*; *3.03.098- Recipient Requirements,3.09.004 – Drug Utilization Review Requirements*.

- Plastic Medicaid identification cards, as defined in *Section 3-Requirements: 3.03.014* (card stock, embossing, mailers and envelopes) - *Recipient Requirements*.

- MMIS hardware and software, and any additional equipment, software upgrades and site licenses necessary to support Agency approved system enhancements. The Vendor shall obtain Agency approval prior to the purchase of any hardware, software, additional equipment, software upgrades or site licenses.

The Vendor shall submit to the Agency for approval, as part of the MMIS Implementation Plan, a plan for determining and documenting pass-through expenses. The Vendor shall make a reasonable effort to obtain the least costly alternative for all pass-through expenses. The Vendor shall take advantage of high volume printing and price comparison-shopping; automation- based rates and service provided by the Postal Service including zip+four, presorting, bar coding and bulk mailing.

6.09.01.05 Enhancements - Personnel/CPU Costs

Payment for work to materially enhance the AMMIS during the operations phase shall be made only when the work to be performed is beyond the requirements expressed in the ITB such as a mandatory project assigned by the Agency which exceeds the scope of work stated in the ITB and the Vendor's proposal and which requires more man-hours than time permits using the contract-required staff. Such payment shall be made in accordance with any contract amendment and shall be calculated using the reimbursement base reflected on *Section 7.07 – Appendix G - Pricing Schedules*.

6.10 Other Requirements

6.10.01 The Vendor's Liaison

The Vendor's Account Manager shall serve as liaison and shall be available and responsible, as the need arises, for consultation and assistance with the Agency personnel; he/she shall attend, upon request, Agency meetings, meetings and hearings of legislative committees and interested governmental bodies, agencies, and officers; and he/she shall provide timely and informed responses to operational and administrative problems whenever arising in administration of the Alabama Medicaid Program. Whenever the Account Manager is not available, the Vendor shall provide a designated alternate that is fully capable of meeting the requirements of this section.

6.10.02 MMIS Implementation Project Manager (MMIS Coordinator)

The Agency's Implementation Project Manager shall be responsible for coordination of implementation activities with the Vendor. Said MMIS Implementation Project Manager, his/her designee(s), and Agency implementation personnel shall have reasonable access to the Vendor's project personnel, facilities, and records for evaluating the quality, appropriateness, and timeliness of deliverables. The MMIS Implementation Project Manager shall have authority on a reasonable basis to call meetings with the Vendor's Account Manager or designee and project personnel, as required, and to assign appropriate technical personnel of the Agency to work with designated staff of the Vendor.

6.10.03 Inspection of Work Performed

The Agency or its authorized representative shall have the right to enter into the premises of the Vendor and all subcontractors, or such other places where duties under the contract are being performed, to inspect, monitor or otherwise evaluate (including periodic testing/validation/verification) the work being performed. All inspections and evaluations shall be performed in such a manner as will not unduly delay work.

6.10.04 Agency's Liaison

The Agency's Fiscal Agent Liaison Officer shall be responsible for coordination of Agency functions and activities with the Vendor, during the operations phase. Said Liaison Officer, his/her designee(s), and Agency audit personnel shall have reasonable access to the Vendor's project personnel, facilities, records, and any portion of the Vendor's bookkeeping system and financial system relating to the Medicaid Program for the purpose of monitoring and evaluating the quality, appropriateness, and timeliness of services. The Fiscal Agent Liaison Officer shall have authority on a reasonable basis to call meetings with the Vendor's Account Manager or designee and project personnel, as

required, and to assign appropriate technical personnel of the Agency to work with designated staff of the Vendor.

6.11 Damages

6.11.01 Liquidated Damages

The purpose of liquidated damages is to ensure adherence to the performance requirements in these Contracts. No punitive intention is inherent. It is agreed by the Agency and the Vendor that, in the event of a failure to meet the performance requirements, damage shall be sustained by the Agency, and that it is and shall be impractical and extremely difficult to ascertain and determine the actual damages which the Agency shall sustain in the event of, and by reason of, such failure; and it is therefore agreed that the Vendor shall pay the Agency for such failures at the sole discretion of the Agency according to the following subsections. Liquidated damage assessments are linked to performance of system implementation or operational responsibilities, as specified in *Section 2 – Statement of Work* and *Section 3 – Requirements* and fulfillment of the requirements as stated in the:

- Executed contract,
- ITB, and any amendments thereto,
- The Vendor's response to the ITB,
- The Agency's written responses to prospective Bidders' questions, and
- The Vendor's clarifications as requested by the Agency during the evaluation process.

Written notification of each failure to meet contractual requirements shall be given to the Vendor. The imposition of liquidated damages is not in lieu of any other remedy available to the Agency. The Agency shall withhold from the Vendor reimbursements amounts necessary to satisfy any damages imposed.

A decision by the Agency not to exercise this damage clause in a particular instance shall not be construed as a waiver of the Agency's right to pursue future assessment of that performance requirement and associated damages. The Agency may, at its sole discretion, return all or a portion of any liquidated damages collected, as an incentive to the Vendor for prompt and lasting correction of performance problems. The Vendor will not be liable for failure to meet response time performance requirements when the failure is due to systems external to the AMMIS contract.

6.11.02 Operational Start Date Damages

If, for any reason, the Vendor does not fully meet the operational start date approved in the Detailed Implementation Schedule and a contract amendment delaying this date or

start-up of a portion of the processing requirements listed in *Section 3 – Requirements* has not been approved by the Agency, then the Vendor shall be liable for all costs incurred by the Agency to continue current AMMIS and the Vendor operations. The Vendor shall also forfeit all claims to reimbursement of monthly expenses or operational payments for that month and each month thereafter until the Agency approves operational readiness.

6.11.03 Certification/Recertification Damages

If the AMMIS does not maintain federal certification for full federal financial participation (FFP) retroactive to the approved operational date and it is determined by the Agency that such failure or loss of certification and FFP is due in whole or in part to the Vendor's performance or failure to perform, then the Vendor shall be liable to the Agency for the amount of that portion of lost FFP attributable to the Vendor's performance or failure to perform.

6.11.04 Violation of Cash Management Agreement

If the Agency is penalized by the U.S. Treasury for violation of the Cash Management Agreement due in whole or in part to Vendor error, the Vendor shall be assessed damages equal to the penalty against the Agency.

6.11.05 Correctness of Payments Damages

If an overpayment or duplicate payment is made and that payment is the result of a failure of the Vendor to either utilize available information or to process the claim for reimbursement in accordance with Agency requirements, the Vendor shall be liable for the amount paid, if the Agency cannot make full recovery using reasonable administrative procedures. The Vendor shall notify the Agency immediately upon discovery of any overpayments or duplicate payments, irrespective of cause. The Agency shall withhold from the Vendor reimbursements the amount necessary to satisfy damages resulting from overpayments or duplicate payments. With the prior written consent of the Agency, the Vendor may pursue recovery of these damages paid to the Agency from the providers who received the overpayments or duplicate payments.

6.11.06 Section 2 – Statement of Work Task Completion Damages

One thousand dollars ($1000.00) damages per work day, or any part thereof, shall be assessed for each of the first ten (10) calendar days of delay in meeting a task completion date. Two thousand dollars ($2,000.00) damages per work day, or any part thereof, shall be assessed for each of the next thirty (30) calendar days of delay. Up to four thousand dollars ($4,000.00) damages per work day, or any part thereof, shall be assessed for each additional day of delay after that. These damages shall be in addition to any amounts assessed for failure to maintain federal certification and/or meet the operational start date.

6.11.07 Timeliness of Claims Processing Damages

Twenty thousand dollars ($20,000.00) shall be assessed for the first month of each failure to meet timeliness standards specified in *Section 3 – Requirements*. If the Vendor does not cure said failure to meet the Agency's requirements, forty thousand dollars ($40,000.00) shall be assessed for each consecutive subsequent month a requirement remains unmet. For example, failure to meet the above requirements for four (4) consecutive months shall result in an assessment of damages of one hundred forty thousand dollars ($140,000.00).

6.11.08 Financial Cycle Schedule Damages

Failure on the part of the Vendor to meet the approved financial cycle schedule, including complete and correct remittance advices and payment release, shall result in liquidated damages of twenty thousand dollars ($20,000) per business day. This assessment shall begin on the workday following the scheduled financial cycle date and continue until the financial cycle is executed.

6.11.09 Delivery of Reports Damages

The Agency shall impose on the Vendor liquidated damages of one thousand dollars ($1000.00) per business day for each failure of the Vendor to furnish a required report in an accurate, complete, and usable form to the Agency on or before the due date for such report, or as extended by written agreement with the Agency. Due dates shall be as designated by the Agency. This assessment shall begin on the workday following the due date and continue until such time as the Vendor furnishes the Agency with the report(s) in an acceptable form. Receipt of inaccurate, incomplete and/or unusable reports shall not release the Vendor from damages under this provision. The Vendor shall be subject to this assessment for regularly scheduled reports only if written notification of the Vendor's noncompliance has been given by the Agency prior to the next due date of the report(s) in question. For special request reports, the Vendor shall be subject to this assessment only if written notification of the Vendor's noncompliance has been given within thirty (30) calendar days following the original due date of the report(s) in question. In addition, the Vendor shall be liable for any damages incurred by the Agency due to the Vendor's failure to provide federally-required reports in a timely manner.

6.11.10 System Availability and Response Time Damages

A penalty of seventy-five thousand dollars ($75,000.00) damages per week shall be assessed for each occurrence of system unavailability in excess of five (5) hours during a continuous five (5) day period. A penalty of two hundred dollars ($200.00) damages per day shall be assessed for any AMMIS inquiry or update screen that has a documented response time greater than three (3) seconds for inquiries and five (5) seconds for update transactions at the Agency site.

6.11.11 Automated Voice Response System (AVRS) Availability Damages

One thousand dollars ($1000.00) per hour shall be assessed when the Automated Voice Response System is not available for provider inquiry response for greater than one (1) hour in a day, other than scheduled or Agency-approved down time.

6.11.12 Online Claims Submission and Eligibility Verification System Availability Damages

One thousand dollars ($1000.00) per hour shall be assessed when the online claims submission and eligibility verification system is not available for provider inquiry response for greater than one (1) hour in a day, other than scheduled or Agency-approved down time.

6.11.13 Electronic Claims Management (ECM) System Availability Damages

One thousand dollars ($1000.00) per hour shall be assessed when the ECM system is not available for provider inquiry response for greater than one (1) hour in a day, other than scheduled or Agency-approved down time.

6.11.14 Key Personnel Damages

Fifty thousand dollars ($50,000.00) damages per occurrence shall be assessed for each change in key person, whether proposed in the bid response or currently in the position, who is changed for reasons other than death, resignation, termination for cause or military recall unless replacement is approved by the Agency in advance.

An additional two thousand dollars ($2,000.00) per day per occurrence shall be assessed for any Vendor initiated vacancy (other than terminations for cause) in a key personnel position.

Two thousand dollars ($2,000.00) per day per occurrence shall be assessed for any vacancy in a key personnel position. This assessment shall begin on the forty-sixth calendar day of the vacancy and shall be in addition to any other assessments due to the vacancy.

6.11.15 Compliance with Material Contract Provisions Damages

Written notification of each failure to meet material contract requirements not specifically mentioned above shall be given to the Vendor. The Vendor shall have five (5) days from the date of receipt of written notification of a failure to perform to specifications to cure the failure. However, the Agency may, in its sole discretion, approve additional days if deemed necessary. If the Vendor does not resolve the failure

within this warning/cure time period, damages shall be imposed retroactively to the date of failure to perform. The Agency shall assess liquidated damages in the amount of one thousand dollars ($1000.00) per day for the first ten (10) days until the non-compliance is corrected. On the eleventh day, the Agency shall increase the amount assessed to one thousand five hundred dollars ($1500.00) per day for the next ten (10) days. The daily damages rate shall continue to increase by five hundred dollars ($500.00) at each interval of ten (10) days until compliance is achieved.

6.12 Payment of Damages

Amounts owed the Agency due to liquidated damages shall be deducted by the Agency from any money payable to the Vendor pursuant to this Contract. These amounts may be deducted from any actual damages claimed by the Agency in the event of litigation for non-compliance and default.

6.13 Limitation of Liability

The Agency's remedies and the Vendor's direct liability to the Agency shall be limited to one and a half times the value of the Contract. This limitation shall not apply to tangible property damage or personal injury. The limitation of liability is applicable solely to the Vendor's direct liability to the Agency. Nothing in this section shall be construed as limiting the Vendor's obligation to indemnify the Agency as expressed in the *Indemnification section* of this ITB. The Vendor understands and agrees that its obligation to indemnify the Agency as expressed in the *Indemnification section* of this ITB is not subject to this limitation.

APPENDICES

7.01 Appendix A - Glossary of Terms

Acronym	Definition
.NET	Microsoft's application development framework for Web, server and Smart Client applications.
AB	Aid to the Blind
Access	PC-based database management system and application development language, made by Microsoft, that assists with the transfer of data into reports, invoices, etc.
Ad Hoc Report	A report produced for a particular purpose and not intended to become a permanent reporting requirement; claim detail reporting in support of SURS is a part of normal SURS operations and is not included as an ad hoc report.
ADA	American Dental Association
Adjudicated Claim	A claim that has reached final disposition such that it is either to be paid or denied.
Adjustment	A transaction that changes any information on a claim that has been adjudicated.
Agency	Alabama Medicaid Agency
AMAES	Alabama Medicaid Application and Eligibility System (Recipient Eligibility)
AMMIS	The Alabama Medicaid Management Information System (AMMIS) consists of all subsystems of the AMMIS except the Recipient Subsystem.
ANSI	American National Standards Institute, an accepted standards-setting body for the computer industry.
APD	Advance Planning Document
API	Application Program Interface
AR	Accounts Receivable
ASC	Ambulatory Surgical Center
ASCII	American Standards Code for Information Interchange
AVECS	Automated Voice Eligibility and Claims System
AVRS	Automated Voice Response System
BENDEX	Beneficiary Earnings Data Exchange system; a file containing data from CMS regarding persons receiving benefits from the Social Security Administration.
Bidder	The corporation, partnership, or joint venture (including any and all subcontractors proposed thereby) that submits a timely, complete, and correctly formatted proposal in response to this ITB
Bill	As refers to a bill for medical services, the submitted claim document, or EMC record; may contain one or more services performed.

Acronym	Definition
Business Days	Official hours of operation based on a five (5) day workweek, excluding Saturdays, Sundays, and official state holidays.
Buy-In	A procedure whereby the State pays a monthly premium to the Federal government on behalf of eligible medical assistance clients for Medicare Part B coverage and to purchase Medicare Part A coverage for a limited number of recipients meeting State-defined criteria.
Capitated Service	Any Medicaid-covered service for which a provider receives a capitated payment.
Capitation	A contractual arrangement through which a health plan or other entity agrees to provide specified health care services to enrollees for a specified prospective payment per member, per month.
Capitation Rate	The amount paid per member, per month for services provided at risk.
CASE	Computer-Aided Software Engineering
Case Management	Gatekeeping: in the primary medical provider program and for long-term care, including assessment, brokering, and monitoring of services.
CASS	USPS form #3553
CD	Compact Disk
CFR	Code of Federal Regulations
Checkwrite	Semi-monthly financial adjudication cycle
CLIA	Clinical Laboratory Improvement Amendments of 1988; a federally mandated set of certification criteria and a data collection and monitoring system to ensure proper certification of clinical laboratories.
CMS	Centers for Medicare and Medicaid Services, formerly HCFA
CMS-1500	CMS approved claim form used to bill professional services, formerly HCFA-1500
CO	Change Order
COLD	Computer Output to Laser Disk
Contract	Referring to the written, signed agreements resulting from the ITB, for the implementation and operation of an MMIS and fiscal agent services for the State of Alabama, unless context clearly requires otherwise.
Contract Amendment	Any written alteration in the specifications, delivery point, rate of delivery, contract period, price, quantity, or other contract provisions of any existing contract, whether accomplished by unilateral action in accordance with a contract provision, or by mutual action of the parties to the contract; it shall include bilateral actions, such as change orders, administrative changes, notices of termination, and notices of the exercise of a contract option.

Acronym	Definition
Cost Avoidance	The payment methodology of avoiding part or all of Medicaid's payment when a third party resource is available to pay a claim.
COTS	Commercial Off the Shelf
CPHA	Committee on Professional and Hospital Activities, which submits update tapes to the states for ICD-9-CM
CPT	Common Procedure Terminology
CPU	Claims Processing Unit
CROCS	Comprehensive Recipient On-line Collection System
CSR	Customer Service Request
Days	See business days
DBA	Doing Business As
DBMS	An integrated (object-oriented or relational) comprehensive database management system, including all data and all internal and linked databases.
DDI	Design, Development, and Implementation
DEA	Drug Enforcement Agency
DEERS/TriCare	Defense Enrollment Eligibility Reporting System/TriCare
DHR	State of Alabama Department of Human Resources
Deliverable	A product of a task milestone or MMIS requirement.
DESI	Drug-Effectiveness Source Identifier
DPH	State of Alabama Department of Public Health
DIS	Detailed Implementation Schedule
DME	Durable Medical Equipment
DMERC	Medicare Durable Medical Equipment Regional Carrier – provides the durable medical equipment crossover file
DMH/MR	State of Alabama Department of Mental Health/Mental Retardation
Drug Data Warehouse	Data base of drug prices and other drug related information used by the AMMIS. Currently First Data Bank supplies the drug data warehouse information.
DSD	Detailed System Design document
DSS	Decision Support System
DTL	Detail
DUR	Drug Utilization Review
DUR Board	The State's Drug Utilization Review Board, composed of physicians, pharmacists, and others experienced in drug therapy problems; the Board makes recommendations to the Alabama Medicaid Agency on DUR policies and procedures
DVD	Digital Video Disk
DYS	State of Alabama Department of Youth Services
ECM	Electronic Claims Management
ECS	Electronic Claims Submittal
EDB	Enrollment Data Base
EDI	Electronic Data Interchange

Acronym	Definition
EDS	Electronic Data Systems, the current Medicaid fiscal agent Vendor for Alabama
EFT	Electronic Funds Transfer
EHR	Electronic Health Record
EIS	Executive Information System
Eligibility Files	The files which contain Medicaid recipient eligibility data. The Master Eligibility File (AMAES) is currently maintained by Medicaid on the ISD mainframe. An extract from this file is transferred nightly to the Vendor. The Vendor currently loads this file by original Medicaid number to create the Recipient Eligibility File for use in processing claims.
EMC	Electronic Media Claims
Encounter	A record of a medically related service (or visit) rendered to a Medicaid recipient who is enrolled in a participating health plan during the date of service; it includes (but is not limited to) all services for which the health plan incurred any financial responsibility.
Encounter Data Claim	A claim submitted by a coordinated care provider for the actual provider of service to plan enrollee. These claims go through full adjudication to determine payment, if any, which would have been made if the recipient had not been under the plan. On the provider's remittance advice these claims show as denied for plan coverage.
EOB	Explanation of Benefits
EOMB	Explanation of Medical Benefits
EOP	Explanation of Payments
ETG	Episode Treatment Grouper
EPSDT	Early and Periodic Screening, Diagnosis, and Treatment for medical, dental, vision, and hearing services.
ETL	Extract Transform and Load
EVS	Electronic Verification System for verifying eligibility
FDB	First Data Bank - a private firm supplying drug prices and other information to the AMMIS.
FEIN	Federal Employee Identification Number
FFP	Federal Financial Participation; a percent of State expenditures to be reimbursed to the State by the Federal government for medical services and for administrative costs of the Medicaid program.
FFS	Fee-For-Service
FIPS	Federal Information Processing Standards
FIPS PUB	Federal Information Processing Standards Publication
Financial Cycle	The processing of claims from adjudication to payment. A financial cycle includes the updating of financial history and the preparation of provider payments and remittance advices.

Acronym	Definition
	Actual release of payments is not considered part of the financial cycle.
Fiscal Year (Federal/State)	October 1 - September 30
FMAP	Federal Medical Assistance Percentage
FP	Family Planning
FQHC	Federally Qualified Health Center
FY	Fiscal Year
FYTD	Fiscal Year To Date
GIS	Geographic Information System software package (e.g. GEOACCESS). A software package that allows geographical information to be displayed using maps.
GUI	Graphical User Interface. A graphical user interface is a "point and click" interface to a program composed of menus, dialog windows, push-buttons, etc.
HCBS	Home and Community Based Services
HCPCS	Healthcare Common Procedure Coding System; a uniform health care procedural coding system approved for use by CMS, describing the physician and non-physician patient services covered by the Medicaid and Medicare programs and used primarily to report reimbursable services provided to patients.
HEDIS	Healthcare Effectiveness Data and Information Set
HHS	Health and Human Services. Refers to U.S. Department of Health and Human Services
HIPAA	Health Insurance Portability and Accountability Act
HIPP	Health Insurance Premium Payment
HIS	Health Information System
HIT	Health Information Technology
HL7	Health Information 7 (Standards for exchanging medical information)
HMOs	Health Maintenance Organizations
ICD-9-CM	International Classification of Diseases, 9th Revision, Clinical Modification
ICD-10-CM	International Classification of Diseases, 10th Revision, Clinical Modification
ICF	Intermediate Care Facility
ICF-MR	Intermediate Care Facilities for the Mentally Retarded; services are covered for those who are mentally retarded or who have related conditions.
IIS	Information Internet Server
I/S	Alabama Medicaid Information Systems Division
ISD	Alabama Finance Department Information Services Division
IT	Information Technology

Acronym	Definition
ITB	Invitation to Bid
ITF	Integrated Test Facility; allows the Agency and Vendor to monitor the accuracy of the MMIS and to test proposed changes to the system by processing test claims and other transactions through the system without affecting normal operations.
IV&V	Independent Verification and Validation
JAD	Joint Application Design
JCAHCO	Joint Commission on the Accreditation of Health Care Organizations
JCL	Job Control Language
Key Date	A specified date which, if not met, may jeopardize the operations start date.
LAN	Local Area Network
LHW	Living at Home Waiver
Lock-In	A recipient who has been identified as abusing the Medicaid program may be restricted, or "locked-in," to a specified physician and pharmacy. The recipient's eligibility record will indicate that the recipient is restricted. Only claims from the specified providers shall be paid, except as otherwise authorized by Medicaid.
LTC	Long-Term Care, used to describe institutional-based services such as nursing facility and ICF/MR facility care.
MAC	Maximum Allowable Charge for drugs
Managed Care	A comprehensive approach to the provision of health care that combines clinical services and administrative procedures with an integrated, coordinated system to provide timely access to cost-effective primary care and other medically necessary services.
MARS	Management and Administrative Reporting System of the AMMIS
MCS	Managed Care Systems (MCS) refers to the following type of programs: capitated; Primary Care Case Management (PCCM); Prepaid Inpatient Health Plans (PIHP); Maternity Care, Plan 1st and premium payment , etc.
Manual Check	A check issued by the fiscal agent which is not routinely generated by the system during a financial cycle.
Medicare Buy-In	See Buy-In
MEQC	Medicaid Eligibility Quality Control
MH	Mental Health
MITA	Medicaid Information Technology Architecture
MLIF	Medicaid for Low Income Families
MMA	Medicare Modernization Act of 2003
MMIS	Medicaid Management Information System
MR/DD	Mentally Retarded / Developmentally Disabled

Acronym	Definition
MS	Microsoft or Mississippi
MSIS	Medicaid Statistical Information System
Must	Indicates a mandatory requirement or condition to be met; see "shall" and "will"
n-tier	Multi-tier application architecture
NCPDP	National Council for Prescription Drug Programs (current standard is 5.1 but is changing in the near future to D.0)
NDC	National Drug Code; a generally accepted system for the identification of prescription and non-prescription drugs available in the U.S.
NPI	National Provider Identifier
NDM	Network Data Mover
NET	Non-Emergency Transportation
NF	Nursing Facility; a long-term care facility licensed under State law and certified by Medicare to provide skilled and intermediate levels of care.
Objection	An unwillingness to accept or acknowledge a mandatory requirement.
OBDC	Open Database Connectivity
OBRA	Omnibus Budget Reconciliation Act
OIG	Office of the Inspector General
On-Line	Use of a computer terminal with visual display to immediately access computer files.
OSCAR file	CLIA file and updates from CMS
OSI	Open Systems Interconnection
PA	Prior Authorization
PAC	Provider Assistance Center
PAR	Prior Authorization Request
Part A	Medicare coverage which typically pays for inpatient hospital expense.
Part B	Medicare coverage which typically pays for outpatient healthcare expense including doctor fees.
Part D	Medicare prescription drug plan
PASARR	Preadmission Screening and Annual Resident Review
Pass-through Expenses	Those expenses of the Vendor which are to be reimbursed at cost by Medicaid.
Patient Liability	Monthly income of a recipient in a long-term care or inpatient setting for more than thirty (30) days which must be applied to cost of care before Medicaid payment is made
PBRHC	Provider Based Rural Health Clinic
PC	Personal Computer
PCCM	Primary Care Case Management
PEC	Post Extended hospital Care
PETI	Post Eligibility Treatment of Income

Acronym	Definition
PIHP	Prepaid Inpatient Health Plan
PMF	Provider Master file
PMP	Primary Medical Providers
POS	Point-Of-Service/Sale (also place of service on claims)
PRO	Peer Review Organization
Processed Refund	The correction of claim history performed in accordance with the instructions attached to a provider refund check.
Pro-DUR	Prospective Drug Utilization Review
Protest	A complaint about a governmental action or decision brought by a prospective Bidder to the appropriate administrative section with the intention of achieving a remedial result.
QA	Quality Assurance
QC	Quality Control
QDWI	Qualified Disabled Working Individual
QMBs	Qualified Medicare Beneficiaries; Medicare Part A beneficiaries whose income is under one hundred percent (100%) of the poverty level but whose income or assets are too high to qualify for other regular Medicaid benefits.
QWDI	Qualified Working Disabled Individual
RCC	Recipient Call Center
Refund	A repayment made by a provider, usually needed because of an error in billing, receipt of a late insurance payment or a duplicate payment which resulted in an overpayment by Medicaid for services rendered.
RDD	Requirements Definition Document
RDS	Recipient Data Sheet
RDT	Requirements Definition Task
REOMBs	Recipient Explanation Of Medical Benefits
RA	Remittance Advice
Returned Claim	A claim which is returned to the provider prior to entry into the system due to lack of clean claim data or a claim which is returned after deletion.
RHC	Rural Health Clinic
RID	Recipient Identification Number
RPF	Recipient Policy File
RSD	Requirement Specifications Document
RTM	Requirements Traceability Matrix
RTP	Returned To Provider
SAIL	State of Alabama Independent Living Waiver
S-CHIP	State Children's Health Insurance Program
SDX	State Data Exchange System; the Social Security Administration's method of transferring SSI entitlement information to the State.
Shall	Indicates a mandatory requirement or condition to be met; see

Acronym	Definition
	"must" and "will"
SLIMB	Specified Low-Income Medicare Beneficiary; Medicare Part A beneficiaries under one hundred twenty percent (120%) of the Federal poverty level who have income or assets that are too high to qualify for regular Medicaid benefits.
SMM	State Medicaid Manual
SNF	Skilled Nursing Facility; an institution (nursing facility) licensed under State law and certified by Medicare to provide skilled nursing and rehabilitative services.
SOA	Service Oriented Architecture
SOBRA	Sixth Omnibus Budget Reconciliation Act
SOW	Statement of Work
SQL	Structured Query Language for the definition, organization, and retrieval of data in a database management system (DBMS), including the tools for transaction, management, data integrity, and data administration.
SSA	Social Security Administration of the Federal government
SSI	Supplemental Security Income
SSL	Secure Sockets Layer
SSN	Social Security Number
State	The State of Alabama; refers to policies, decisions, procedures, receipt of data, and the like that are defined by Alabama State agencies.
State Plan	The State Plan for Medical Assistance of the State of Alabama as approved by HHS for federal financial participation under Title XIX of the Social Security Act, as amended.
Subcontractor	Any and all corporations, partnerships, agents, and/or individuals retained by the Vendor (with prior written approval from the State) to perform services under this ITB, regardless of the amount, duration, or scope of the services provided and regardless of whether identified in the Vendor's proposal in response to this ITB or subsequently retained during the contract term.
SURS	Surveillance and Utilization Review Subsystem; a federally-mandated MMIS subsystem that builds a statistical base for health care delivery and utilization pattern profiles for both providers and recipients and generates a listing of potential abusers for review by the Alabama Medicaid Agency.
TANF	Temporary Aid for Needy Families
TCM	Targeted Case Management
Title IV-E	The title of the Social Security Act which is an entitlement program providing Federal financial participation for the costs of foster care maintenance and adoption assistance payments.
Title XIX	Of the Social Security Act enacted Medicaid in 1965;

Acronym	Definition
	synonymous with Medicaid
Title XVIII	Of the Social Security Act (Medicare)
TPL	Third Party Liability
TPR	Third Party Resource
TFQ	Together for Quality
TQM	Total Quality Management
UB-04	Standard claim form developed by National Uniform Billing Committee (NUBC) used to bill institutional services.
UPIN	Universal Provider Identification Number
USPS	United States Postal Service
VANs	Value Added Networks
Vendor	Bidder with whom the State has successfully executed a contract under this ITB. Fiscal Agent may refer to Vendor within this document.
WAN	Wide Area Network
WBS	Work Breakdown Structure
WIC	Women, Infants, and Children's program
Will	Indicates a mandatory requirement or condition to be met; see "must" and "shall"
Working Days	See Business Days
Workshops	General statewide training sessions conducted by the Vendor to educate providers regarding proper billing procedures.
YTD	Calendar Year-To-Date

NOTE: Other terms referenced in this ITB shall comply with definitions contained in applicable state and federal laws and regulations.

7.02 Appendix B - Forms

7.02.01 Attachment 1 - Implementation Contract

Implementation Contract

State of Alabama
Montgomery County

KNOW ALL MEN BY THESE PRESENTS, that the Alabama Medicaid Agency, an Agency of the State of Alabama, and the undersigned Vendor agree as follows:

Vendor shall furnish all labor, equipment, and materials and perform all of the work required for implementation activities under the Invitation to Bid, No. 10-X-2205737 dated February 2010, strictly in accordance with the Invitation to Bid's requirements and the Vendor's bid response.

Vendor shall begin performance of implementation activities in accordance with the schedule outlined in Section 2- Statement of Work of the Invitation to Bid.

Vendor shall be compensated for performance of these implementation activities in accordance with the schedule outlined in Section 6.09 and Pricing Schedule B of the Invitation to Bid.

This contract specifically incorporates by reference the said Invitation to Bid, any amendments thereto, and Vendor's bid response, including all attachments.

Vendor

_____
Title

_____
Vendor's Legal Counsel

APPROVED

_____
Finance Director, State of Alabama

Alabama Medicaid Agency
This contract has been reviewed for and
is approved as to content.

_____
Commissioner

This contract has been reviewed for legal form and complies with all applicable laws, rules, and regulations of the State of Alabama governing these matters.

_____
Medicaid Legal Counsel

APPROVED

_____
Governor, State of Alabama

7.02.02 Attachment 2 - Operations Contract

Operations Contract

State of Alabama
Montgomery County

KNOW ALL MEN BY THESE PRESENTS, that the Alabama Medicaid Agency, an Agency of the State of Alabama, and the undersigned Vendor agree as follows:

Vendor shall furnish all labor, equipment, and materials and perform all of the work required under the Invitation to Bid, No. 10-X-2205737, dated February 2010, strictly in accordance with the requirements thereof and Vendor's bid response thereto.

Vendor shall be compensated for performance under this contract in accordance with the provisions of Section 6.09 and Pricing Schedules C and D.

This contract specifically incorporates by reference the said Invitation to Bid, any amendments thereto, and Vendor's bid response, including all attachments.

Vendor	Alabama Medicaid Agency This contract has been reviewed for and is approved as to content.
_____ Title	_____ Commissioner
	This contract has been reviewed for legal form and complies with all applicable laws, rules, and regulations of the State of Alabama governing these matters.
_____ Vendor's Legal Counsel	_____ Medicaid Legal Counsel
APPROVED	APPROVED
_____ Finance Director, State of Alabama	_____ Governor, State of Alabama

7.02.03 Attachment 3 - Intent to Bid Notification

Intent to Bid Notification

INTENT TO BID

ITB #10-X-2205737

This sheet acknowledges that _____ (company name) intends to bid on ITB #10-X-2205737.

COMPANY NAME

_____

REPRESENTATIVE'S NAME

_____

COMPANY ADDRESS

_____

_____

Phone: _____

FAX: _____

E-mail: _____

Date: _____

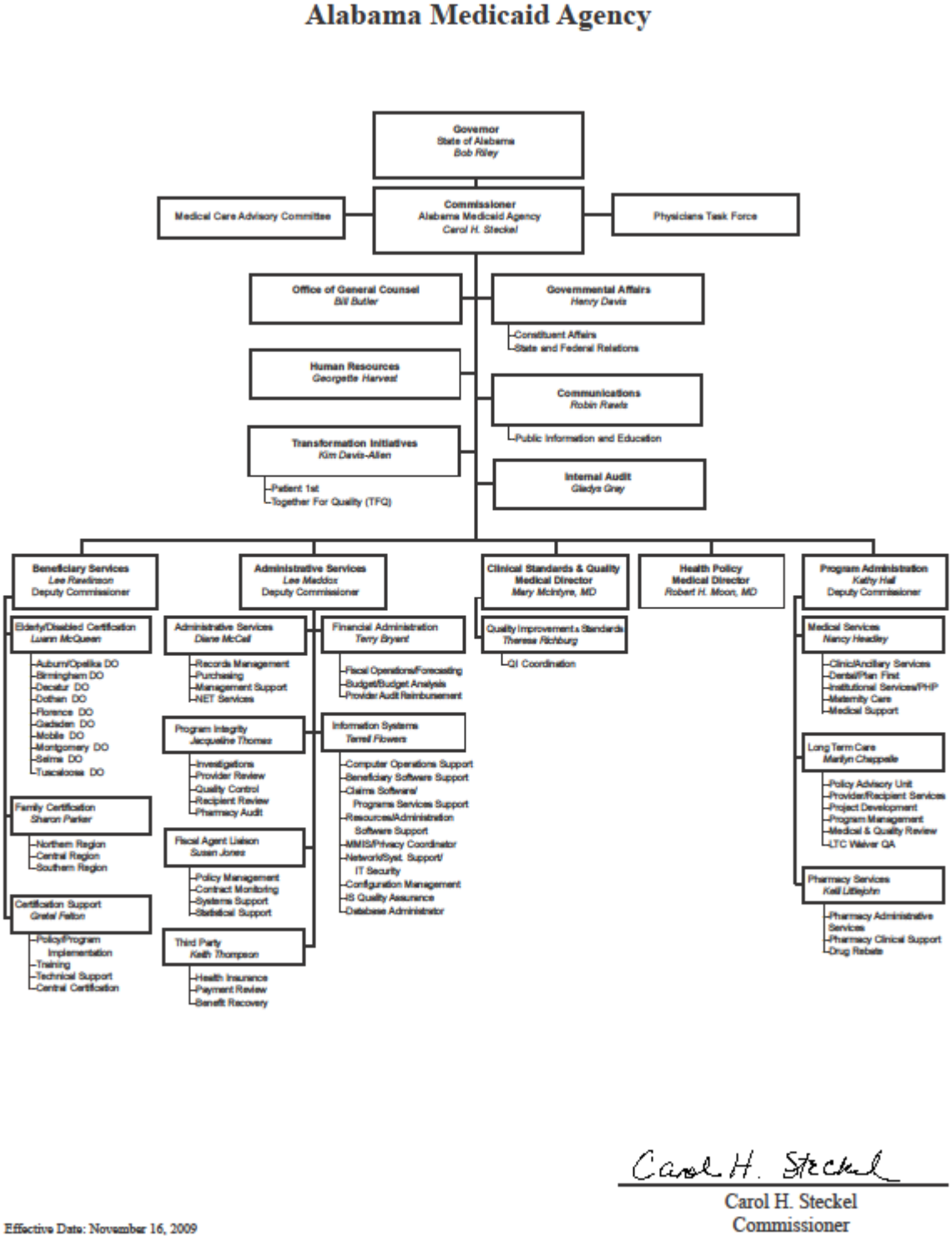
7.03 Appendix C - Overview of MMIS Recipient Subsystem

The following is provided by the Information Systems Division of the Alabama Medicaid Agency to describe our current Recipient Processing Subsystem:

SUBSYSTEM	MAJOR FUNCTIONS/DESCRIPTIONS:
Alabama Medicaid Application and Eligibility System (AMAES)	File contains at least five (5) years of data on approximately 1.2 million Medicaid eligibles including those certified by the Social Security Administration (SSA), Department of Human Resources (DHR), Department of Youth Services (DYS), and detailed data on all applications processed by the Medicaid District Offices and SOBRA Outstation locations. This file is updated by the following processes: batch programs, daily data files from DHR and SSA, and on-line access at the Medicaid Central office, District offices, outstationed SOBRA workers, and DHR. **MAJOR FUNCTIONS INCLUDE:** 1. Provide on-line software to allow users INQUIRY and UPDATE capability on the AMAES file, Provide STATISTICAL DATA & VARIOUS REPORTS to other in-house Agency users and other state agencies as required, 2. Provide on-line capability to GENERATE VERIFICATION LETTERS for District Office and SOBRA recipients (Letters are generated for banks, tax assessors, nursing homes, SSA, and the Veterans Administration.), 3. Provide capability to generate on-line AWARD, DENIAL and TERMINATION LETTERS for SSA, District Office and SOBRA recipients, 4. Provide capability to generate and calculate on-line BUDGETS for Eligibility determinations and for annual reviews for District Office and SOBRA recipients, 5. Provide DAILY ON-LINE TRANSMISSION OF DATA from Medicaid to our fiscal agent to be used in online claim submission, eligibility

SUBSYSTEM	MAJOR FUNCTIONS/DESCRIPTIONS:
	verification, and claims editing and adjudication, 6. Perform several vital annual processes to the Eligibility File data such as the COLA (COST OF LIVING ADJUSTMENTS).
MEDICARE	This data is maintained on the AMAES file. The Centers for Medicare and Medicaid Services (CMS) supplies monthly BUY-IN data for Alabama's recipients with Medicare Parts A, B and/or D.
BENEFICIARY	The Beneficiary Earnings Data Exchange (BENDEX) File contains data concerning the Social Security payments being made to Alabama Medicaid recipients. This information is updated by electronically transmitted data sent by the Social Security Administration (SSA) and is accessible on-line by the Agency staff.
STATE DATA EXCHANGE (SDX) File	State Data is maintained on the file for Supplemental Security Income (SSI) recipients and is accessible on-line to the agency staff. SSA transmits daily update files of additions and terminations for those SSI recipients eligible for Medicaid in Alabama.
MSIS	The Information Systems Division supplies ELIGIBILITY DATA Files to CMS via Medicaid Statistical (MSIS) Files on a quarterly basis. However, to create this quarterly information, data is collected on a monthly basis from our Eligibility (AMAES) File and combined on these MSIS files.
STATE VERIFICATION EXCHANGE SYSTEM (SVES)	This system provides the data exchange of the Social Security numbers (standard response), Title II (BENDEX) data and Title XVI (SDX) data by overnight direct electronic transmission of all recipients of federally funded aid in order to fully utilize the Social Security Administration's data to help establish eligibility and ineligibility in Alabama. This data as it is received from SSA is on-line accessible to the Agency staff.
PSEUDO SSN SYSTEM	This system is used online by Agency eligibility workers to assign a temporary Social Security Number to a recipient until the recipient receives a valid SSN from the Social Security Administration and Medicaid is notified of that number or until an "unborn child" on our Eligibility File has actually been born and the parent can now apply for eligibility. These "pseudo" numbers are system generated, confirmed by the workers, and permanently tied to the recipient's valid SSN and future data received for that recipient.

7.04 Appendix D - Medicaid Organizational Chart



Carol H. Steckel

Carol H. Steckel
Commissioner

Effective Date: November 16, 2009

7.05 Appendix E - Current Program Statistics

7.05.01 Alabama Medicaid Adjudicated Claims Experience (Line Items)

Invoice Category	FY02	FY08
Nursing Facility	289,585	334,021
ICF	0	0
Inpatient Hospital	89,580	170,884
Outpatient Hospital	2,271,063	3,512,950
Ambulatory Surgical	14,823	21,787
Home Health	158,695	293,204
Family Planning - Inst.	23	1,540
Inpatient Psych Hosp.	3,786	13,997
FP - FQHC	8,428	14,445
Hospital - Other	2,684	276
Sterilization - Hosp.	2,443	4,020
PBRHC	221,663	197,064
MR/DD Waiver (HCBS)	83,060	786
Mental Health Services	1,579,236	1,661,128
ICF-MR Public	5,591	2,953
ICF-MR Private	297	820
Nursing Facility - MD (Mental Disease)	4,410	696
TCM - MI (Mentally Ill)	115,816	87,726
OBRA'87 Waiver	0	0
Substance Abuse	75,681	59,023
E&D Waiver - DPH (HCBS)	92,972	167,506
E&D Waiver - Department of Senior Services (HCBS)	98,835	183,771
E&D Waiver - DHR (HCBS)	0	851,308
MHS/Rehab (DHR)	1,177,922	439
TCM - Adult PSI (Protected Services Individual)	8,157	5,798
TCM - MR Adults	86,929	110,084
Hospice	22,703	9,534
Preventive Health Education	17,303	3,216
Drugs	10,469,896	9,327,393
Family Planning Drugs	54,238	82,181
Homebound Waiver (HCBS)	15,639	23,548
Physicians	5,169,892	6,332,959
Dental	1,025,744	1,844,720
Optometrist	286,667	390,691
Eyeglasses	206,386	264,322
Lab	732,290	958,560
Free Standing Radiology	39,996	96,291
EPSDT	584,021	898,940
Hearing	13,118	7,585
State Lab	368,412	692,605
Family Planning - Physician	23,115	87,121
Family Planning - Clinic	75,928	40,432
Transportation	280,327	333,663

Invoice Category	FY02	FY08
DME	565,644	746,073
Rural Health Clinics	137,389	192,777
Maternity Waiver/Care	27,522	36,138
FQHC	747,541	699,855
Private Duty Nursing	9,322	7,051
Other Practitioner	58,378	123,821
TCM - Handicapped Children	81,253	81,720
TCM - Foster Children	59,320	77,014
TCM - Prenatal	11,172	366
TCM - AIDS	10,014	9,337
Therapists	84,779	114,904
Medical - Other	155,820	153,233
Nurse Midwife	1	2,006
Prenatal Clinics	6,157	526
FP - Preventive Health Education	156	4,521
Sterilizations - Physicians	7,777	6,170
Rehab	0	512
CRNA (Certified Registered Nurse Anesthetist)/Nurse Practitioner	34,364	264,986
Physician Lab & X-Ray	2,428,091	2,325,159
Renal Dialysis Centers	69,490	77,312
Drug Case Management - Clozaril	8,192	520
Family Planning - Lab	20,675	31,683
DME – Drugs	77,653	62,562
TCM - Renal Dialysis	50,459	55,456
Children's Specialty Clinic	11,302	10,519
FP - PBRHC	295	2,453
Clinics – DPH	4090	2,614
FP – RHC	13	1,254
Medicare HMO	87	1,002
FP 1115 Waiver	365,009	551,872
FP 1115 Waiver Education	113,835	157,162
FP 1115 Drugs	5,378	62,776
Total	**30,952,132**	**34,953,341**

7.05.02 Estimates of Run Times, Hardware Requirements, and Languages for the AMMIS

1. Run time for month's processing (Includes items 2 -5): accumulation of items 2-4
   - 575 hours CPU time (Production)

2. Financial cycle:
   - Cycle time: 38 hours

3. MAR cycles:
   - Monthly Cycle time: 30 minutes
   - Quarterly MSIS Cycle Time: 4 hours

4. SUR Quarterly
   - Profiler Cycle time: 124 hours
   - ETG Cycle time: 16 hours

5. Adjudication cycle:
   - The Financial cycle comprises 104 jobs & programs in its execution.

6. Type of operating system:
   - Solaris 10

7. I-0 devices:
   - Connect Direct
     - 1-Dell PE6950 w/Windows 2003 Virtual Server
   - SFTP
     - SUN T2000
     - Solaris 10
   - CPUs
     - 8GB RAM
   - Tape Drive
     - Qualstar M2448SA Tape Drive

8. File sizes: 9 TB allocated

9. Claims processing record size:
   - Length of 1 detail pharmacy txn = 182 kb small record size

- Length of 837I txn (UB02) with 999 details = 271745 kb large record size

10. Largest program size in bytes and average program size:
    - Largest program - 2,074,546 bytes
    - Average program - 33,036 bytes

11. Number of jobs run:
    - Claims - 60 daily, 7 weekly, 9 monthly, 3 quarterly, 12 on request
    - DSS - 2 daily, 11 weekly, 22 semi-monthly, 6 monthly, 34 on request
    - Drug Rebate - 3 daily, 4 weekly, 7 monthly, 24 quarterly, 5 on request
    - DUR - 17 daily, 4 weekly, 56 monthly, 17 yearly, 1 on request.
    - EDI - 28 daily, 5 weekly, 5 monthly
    - Eligibility/Recipient - 36 daily, 10 monthly, 1 yearly, 9 on request
    - EPSDT - 2 monthly, 1 quarterly, 1 yearly
    - Financial - 2 daily, 101 weekly, 17 monthly, 3 quarterly, 6 yearly, 12 on request
    - LTC - 4 daily, 1 monthly, 1 on request
    - Managed Care - 20 daily, 6 weekly, 69 monthly, 1 on request
    - MAR - 18 monthly, 20 quarterly, 39 yearly, 2 on request
    - Prior Authorization - 5 daily, 7 monthly,
    - Provider - 6 daily, 7 weekly, 10 monthly, 1 semi-monthly, 1 quarterly, 2 yearly, 6 on request
    - Reference - 2 daily, 23 weekly, 13 monthly, 10 quarterly, 8 yearly, 5 on request
    - SUR - 2 daily, 42 on request
    - System Wide/Ops - 18 daily, 2 weekly, 3 monthly, 1 quarterly, 2 yearly
    - TPL - 16 daily, 24 weekly, 82 monthly, 3 quarterly, 3 yearly, 16 on request

12. Lines of code: approximately 2,563,013 lines of batch code

13. Languages:
    - C, Pro C
    - C#
    - Perl,
    - .net/asp,
    - Korn Shell and c shell
    - General UNIX utilities such as vi editor, ot sort and sftp.
    - Jil
    - sql
    - JavaScript
    - Ajax
    - html, htm
    - Visual Basic
    - Microsoft Visual FoxPro

14. Electronic Claims Submission Hardware
    - 8-Dell 6850's PowerEdge, as ESX VMWare Host servers
    - 1-Dell 1850 PowerEdge – VirtualCenter server
    - Cisco AS5350XM Universal Gateway (for dial-up purposes)
    - 1 ISDN PRI circuit (for dial-up purposes)

15. Voice Response System Hardware:
    - HP Proliant ML370 Server
    - InterVoice BRITE TRM-520 Server
    - 45 phone lines

16. DSS
    - SUN E25K
    - Solaris 10
    - 12 Processors
    - 80 GB of Memory

17. WEB Server
    - UI Servers
        - 4-Windows 2003 Virtual Server
    - Web Portal
        - 3- Windows 2003 Virtual Servers

7.05.03 Provider Statistics FY 2009

- Provider Education via On-Site Visits - 1,653
- Provider Association Interaction - 10 Annually
- Provider Manuals Update & Distribution - 1 distribution annually
    - (approximately 5500 providers)
- Provider On-Site Workshops - 6
- Provider Bulletin Preparation - 4
- Internal & Agency Staff Training Sessions - 5
- SUR Follow - Up Education - (Included in provider visits)
- Mini-Memo File Updates - 24
- Newly Enrolled Provider Follow - up - (Included in provider visits)
- Telephone Inquiries
    - PAC - 212,557
    - RCC - 556,372
    - ECS - 42,506
    - Reps - 30,630
- Written Inquiries
    - PAC - 401
    - Reps - 7,891
    - EMC - 2058
    - RCC - 85,352 approximately
    - Patient 1st requests - 103,855
    - Returned forms to recipients - 8,482
    - Faxes sent to providers - 1,111
- Claims Adjustments - 24,900
- Refund Processing - 21,852 refund transactions processed
- Provider AVRS - 212,628 transactions annually
- Recipient AVRS - 78,520 transactions annually
- Provider Enrollment (Adds) – 9,708
- Provider File Updates (Changes) – 29,996
- Provider File Rate Updates – 550 (Hospital only)
- Provider File Worksheet Resolution – 11,040
- Paper Claims Receipt & Processing – approximately 1,287,768
- RTP (Return to Provider) Processing – 32,460

- Claim Form Distribution & Tracking – 160,932
- Provider Bulletin Distribution - approximately
    - Mail - 16,923
    - E-mail - 2,168
    - Fax - 944
- REOMBS – approximately 2800 per month

7.05.04 Medicaid Mail Activity

Type of Mail-out	FY 2002 Volume
1099	5,148 annually
REOMBs	2,800 monthly
Provider Manuals	CDROM - 6,850 annually Paper - 84 annually
Provider Bulletins	Mail - 16,923 annually E-mail - 2,168 annually Fax - 944 annually
Explanation of Payments (RAs)	7,800,000 pages annually
Returned to Provider (RTP)	32,460 annually
Provider Correspondence Recipient Correspondence	649,224 annually 80,592 annually

Vendor is responsible for production and complete mail service for entries listed above.

7.05.05 Data Entry and Claims Resolution Statistics Fiscal Year 2009

- Data Entry
    - Paper Claims Entered – approximately 1,287,768
    - Worksheet Resolution – approximately 733,512
    - Resolutions Manual Updates – 12

7.05.06 Reference File Statistics Fiscal Year 2009

- Worksheet Resolution – approximately 550,000
- Prior Authorization File Maintenance – 19,812
- Sterilization Claims Review – 6,780
- Data Sheet Distribution – Approximately 17,000 pages per month
- TPL file maintenance – 11
- Pricing file maintenance - 409
- BPA file maintenance - 1433
- Fund code/financial file maintenance – 2
- Diagnosis file maintenance – 166
- Reference file maintenance – 29

7.05.07 Proprietary Software

With the exception of the Provider Electronic Solutions (PES) product described below, EDS utilizes commercially-available software in the construction and operation of the AMMIS.

7.05.07.01 Provider Electronic Solutions (PES)

PES software enables users to submit recipient eligibility requests, electronic claims, and claim reversals and adjustments on behalf of Alabama Medicaid recipients via batch submissions only. PES is available at no charge to Alabama Medicaid providers. All transmissions are encrypted for security.

Batch submission refers to the sending of the following types of submissions in bulk: eligibility verification requests, claims submissions, claim delete requests, and claims inquiries. A batch may contain one record or many records of a single submission type. These transactions are sent for processing from PES software across the public internet to the Alabama Medicaid Secure Web Portal. AMMIS will process batches and return a response to the Web Portal. Providers re-connect to the Secure Web Portal using PES via the public internet to retrieve their responses. All claim types are available for batch transmission.

PES operates in a Microsoft® Windows™ environment. The software is very user-friendly and features point-and-click functionality and on-line help, just like other Windows applications.

Providers who bill Medicaid claims electronically receive the following benefits:

- Quicker claim processing turnaround
- Immediate claim correction
- Enhanced online adjustment functions
- Improved access to eligibility information

7.06 Appendix F - Procurement Library Contents

- Alabama Medicaid Administrative Code (see www.legislature.state.al.us/CodeofAlabama/1975/coatoc.htm)
- Alabama Medicaid Annual Reports (see www.medicaid.alabama.gov)
- Alabama Medicaid 2011 MMIS Procurement Quality Assurance Plan
- Alabama Medicaid Hardware for 2011
- Alabama Medicaid TPL Month-end Process Requirements
- Alabama MMIS CSRs
- Alabama MMIS Interface List
- Alabama MMIS Reports Listing
- Alabama MMIS System Documentation
- Appendix G – Incumbent Vendor Pricing Schedules
- Appendix G – Non-Incumbent Vendor Pricing Schedules
- Appendix L – Business Experience Matrix
- AVRS Manual (see Provider Billing Manual)
- Claim Forms and Required Attachments (see www.medicaid.alabama.gov)
- Claim and Prior Authorization Forms (see Provider Billing Manual)
- Current Fiscal Agent Contract and All Amendments
- Current Fiscal Agent Organization Chart
- Data Element Dictionary
- Drug Reference File Fields
- DUR Outcome Reject Codes (see www.medicaid.alabama.gov)
- Electronic Media Claims Specifications (see www.medicaid.alabama.gov)

- Enrollment Forms for Providers (see www.medicaid.alabama.gov)
- Health Care Common Procedure Coding System (HCPCS) Codes (see http://www.cms.hhs.gov/HCPCSReleaseCodeSets/)
- List of the State of Alabama Holidays (see http://info.alabama.gov/calendar.aspx)
- List of Licensure Boards
- Medicaid Covered Services Handbook (see http://www.medicaid.alabama.gov/documents/Resources/4-G_Publications/4G-1_YourGuideToMedicaid.11-08.pdf)
- Provider Billing Manual (see www.medicaid.alabama.gov)
- Provider Bulletins (see www.medicaid.alabama.gov)
- Resolutions Manual

NOTE: All items shall be available on and after Procurement Library opening date. Items listed as paper are only available in paper form. All other items are available on CD/DVD for a reproduction fee of one hundred dollars ($100.00) which includes shipping and handling.

7.07 Appendix G - Pricing Schedules

7.07.01 Incumbent Vendor Pricing Schedules

- Pricing Schedule A(I) - Incumbent Vendor Evaluated Price
- Pricing Schedule B(I) - Incumbent Vendor Enhancement Deliverables Costs
- Pricing Schedule C(I) - Incumbent Vendor Operations Costs
- Pricing Schedule D(I) - Incumbent Vendor Extra Contractual Services

NOTE: MS Excel Worksheets with Tabs for each schedule will be provided separately at the Pre-Bid Conference.

7.07.02 Non-Incumbent Vendor Pricing Schedules

- Pricing Schedule A(N) - Non-Incumbent Vendor Evaluated Price
- Pricing Schedule B(N) - Non-Incumbent Vendor Operations and Enhancement Deliverables Costs
- Pricing Schedule C(N) - Non-Incumbent Vendor Operations Costs
- Pricing Schedule D(N) - Non-Incumbent Vendor Extra Contractual Services

NOTE: MS Excel Worksheets with Tabs for each schedule will be provided separately at the Pre-Bid Conference.

If the Bidder has problems with the numbers linking between schedules, you may request a non – password protected spreadsheet for manual entry.

7.08 Appendix H - Staffing Requirements

7.08.01 Key Personnel

This appendix includes the general responsibilities, minimum qualifications, and start dates for key personnel for the MMIS contract. Requirements are presented in matrices for:

- Implementation Phase Key Personnel
- Operations Phase Key Personnel

Separate individuals shall be named for each key personnel position and must be dedicated to their responsibilities under this contract, full-time and on-site.

Implementation Phase Key Personnel			
Key Personnel	General Responsibilities	Minimum Qualifications	Start Date
Account Manager	Contract administration, project management, scheduling and provision of resources, formal communication and correspondence with the Agency and Quality assurance.	Required: Five (5) years of management experience for government or private sector health care payer; Bachelor's degree; previous experience with Medicaid and MMIS development.	Contract signing
MMIS Implementation Manager	Schedule, coordinate, and manage all MMIS implementation task activities. Manage requirements definitions sessions between the Vendor and Agency staff and schedule task-level activities. Coordinate installation of all communication lines, gateways, routers and associated equipment.	Required: Four (4) years of experience in system design, development, and implementation efforts in a management capacity; recent experience of at least three (3) years with MMIS; Bachelor's degree in computer science, business administration, or related field.	Contract signing

Implementation Phase Key Personnel			
Key Personnel	General Responsibilities	Minimum Qualifications	Start Date
MMIS Systems Manager	Act as primary technical contact with the Agency. Provide day-to-day liaison with the Agency. Hire and train system maintenance and modification staff. Develop and manage procedures for routine maintenance.	Required: Bachelor's degree in computer science, management information systems, or a directly related field and at least five (5) years of supervisory experience in health care systems design, development, and programming with at least three (3) years of recent experience with the MMIS or major components.	Must be employed no later than four (4) months prior to start of operations. Can be the same person as Implementation Manager.
Operations / Claims Processing Manager	Manage and design all procedures to support all claims processing activities. Develop job descriptions. Hire and train claims processing staff.	Required: At least four (4) years of experience managing claims processing operations personnel of which two (2) years must be previous Medicaid or Medicare experience.	Must be employed no later than four (4) months prior to start of operations.
Customer Relations Manager	Primary point of contact for provider enrollment and training, provider setup for electronic claims submission, provider manual development and maintenance and provider inquiry.	Required: At least two (2) years of experience managing customer service for provider/recipient relations functions for a Medicaid program or other health care program and a Bachelor's degree in public administration or a related field.	Must be employed no later than four (4) months prior to start of operations.

Implementation Phase Key Personnel			
Key Personnel	General Responsibilities	Minimum Qualifications	Start Date
EIS/DSS Technical Support	Provide training and support to State staff. Provide assistance with software (e.g. SQL).	Required: Bachelor's degree in computer science, management information systems, or directly related field; two (2) or more years of experience in RDBMS and structured query tools.	Must be employed no later than six (6) months prior to start of operations.

Operations Phase Key Personnel			
Key Personnel	General Responsibilities	Minimum Qualifications	Start Date
Account Manager	Same as indicated for Implementation Phase.	Required: Same as indicated for Implementation Phase.	Must be employed no later than six (6) months prior to start of operations.
Operations/Claims Processing Manager	Manage and coordinate all routine claims processing operations.	Required: At least four (4) years of experience managing claims processing operations personnel of which two (2) years must be previous Medicaid or Medicare experience.	Must be employed no later than four (4) months prior to start of operations.

Operations Phase Key Personnel			
Key Personnel	General Responsibilities	Minimum Qualifications	Start Date
MMIS Systems Manager	Act as primary point of contact with Agency staff for system maintenance and modification. Schedule, coordinate, and report on maintenance and modification activities. Coordinate use of maintenance and modification task personnel resources. Facilitate implementation of system modifications. Maintain communications including communication lines, gateways, routers, and associated equipment.	Required: Bachelor's degree in computer science, management information systems, or a directly related field and at least five (5) years of supervisory experience in health care systems design, development, and programming with at least three (3) years of recent experience with the MMIS or major components.	May be Implementation Manager. Must be named six (6) months prior to start of Operations.

Operations Phase Key Personnel			
Key Personnel	General Responsibilities	Minimum Qualifications	Start Date
Customer Relations Manager	Primary point of contact for provider enrollment and training, provider setup for electronic claims submission, provider manual development and maintenance, and provider inquiry. Coordinate all provider services activities. Act as primary point of contact for activities related to provider enrollment, recertification, and training. Manage production, maintenance, and distribution of provider manuals.	Required: At least two (2) years of experience managing customer service for provider/recipient relations functions for a Medicaid program or other government health care program and/or a Bachelor's degree in public administration or a related field.	Must be named no later than four (4) months prior to start of Operations.

7.08.02 Other Contract Required Personnel

These individuals are listed in the ITB with specified duties for the performance of the contract.

- Quality Assurance Manager
- Customer Relations Staff
- SURS Analyst (Can serve in another capacity)
- TCM Prior Authorization Coordinator (Can serve in another capacity)
- HCPCS Coordinator (Can serve in another capacity)
- Medical Policy Specialist (Can serve in another capacity)
- Medical Policy Analyst – Registered Nurse with certification as a Certified Professional Coder
- Medical Policy Analyst - With certification as a Certified Professional Coder
- Modification Team members
- Systems/Technical Support
- EIS/DSS Technical Support
- Provider Quality Assurance Evaluator
- EMC Coordinator
- Drug Data Warehouse Coordinator

7.08.03 Modification Team

Minimum qualifications for the members of the Modification Team specified in *Section 6.07.02* include:

Senior Systems Analyst - A minimum of one (1) year of experience in system development and four (4) years progressive experience in maintenance and modification, with recent experience of at least two (2) years with an MMIS or other health care claims processing system, and a Bachelor's degree or a two (2) year degree from an accredited technical program.

Programmer Analyst - A minimum of two (2) years of progressive experience in system development, system maintenance and modification, and a Bachelor's degree or a two-(2) year degree from an accredited technical program.

Junior Programmer - A two (2) year degree from an accredited technical program.

Project Analyst - A minimum of three (3) years project analyst or related experience in a support role of both maintenance and modification activities in a health care claims processing system.

Two thousand (2,000) hours of monthly Modification Team programming time shall consist of at least forty percent (40%) Senior Systems Analyst hours and an additional

forty percent (40%) at the Programmer/Analyst level or above. These analysts must be devoted exclusively to the Modification Team. No supervisory tasks shall be included in these hours.

The Vendor shall also provide a minimum of eight hundred (800) hours of project analyst time each month. The project analysts shall support the modification efforts exclusively. These project analysts will be responsible for supporting the definition of the work and business activities and serve as policy area specialist with specialized knowledge of MMIS components.

In addition, in years one and two of the operations phase of the contract the Vendor shall provider the following additional resources over and above all other resource requirements specified in this ITB to assist the Agency in implementing ICD 10 changes:

- 40 hours per month EIS/DSS support,
- 50 hours per month Senior System support,
- 50 hours per month Programmer/Analyst support,
- 125 hours per month Project Analyst staff support,
- 125 hours per month Provider Relations staff.

The activities of these staff shall be solely at the Agency's direction.

7.09 Appendix I - State Technical Architecture

The Agency currently utilizes 2 platforms – our internal Microsoft Windows 2003 Active Directory domain and ISD State Data Center IBM z/800 Model 2066-003 mainframe computer.

Current Mainframe Narrative

Basic functions of the state data center mainframe computer:

1. Serves as a data repository for many of the data files that Medicaid utilizes on a daily basis. The storage medium consists of disk, tape, cartridge, and optical.

2. Provides access to mainframe application and system software.

3. Provides telecommunication link to Medicaid users for access to files, processors, printers, etc. located at the data center.

4. File transfer with EDS in Montgomery, AL and Orlando, FL.

Current Microsoft Windows 2003 Active Directory Domain Narrative

Basic functions of our internal Microsoft Windows 2003 Active Directory domain:

1. Provides Medicaid users access to internal Medicaid applications; such as the Medicaid Personnel System, Accounts Payable System, Security Awareness Training, etc.

2. Provides authentication and authorization for domain resources.

3. Provides basic file and print services for Medicaid users.

Current Wide Area Network Narrative

Basic functions of the Agency Wide Area Network:

1. Provides access between the nine (9) remote district offices with access to our local area network.

2. Provides connectivity to the ISD mainframe via the campus ring connection.

3. Provides connectivity to EDS resources at the TechnaCenter location.

4. Provides email, DNS, DHCP, and Internet services.

Current Technical Infrastructure

Main office users access the LAN using TCP/IP over Ethernet. The nine (9) external District Offices access the WAN using TCP/IP over Ethernet via T-1 connections to Medicaid's local AT&T POP. A T-1 connects the local POP to a router at the main office. The main office and district offices access the ISD mainframe through an ISD provided VisualConnect 3270 Emulator web browser application.

LAN/WAN Software Standards

- Microsoft Windows XP & Microsoft Vista 32 Bit
- Internet Explorer 6.0 & 7.0
- McAfee Anti-Virus
- Microsoft Office 2007 (Professional)

LAN/WAN Hardware Standards

- IBM z/800 Model 2066-003 mainframe. We are currently running z/OS 1.9.
- Our disk storage consists of two (2) 10TB IBM 2105 Shark storage subsystems. One is used for production data bases and other data sets. The other IBM 2105 will be used to store virtual tape data.
- Our physical tape storage consists mainly of four (4) StorageTek tape cartridge silos housing both 200MB and 20GB tapes. We plan to migrate to the aforementioned virtual tape system (late summer 2009) and will upgrade our physical tapes to IBM 3592 Model 500GB tapes housed in an IBM 3494 Automatic Tape Library (ATL). Upon successful implementation of the virtual tape system and the ATL the four (4) StorageTek silos will be de-installed.
- We are establishing a Disaster Recovery (DR) data center in the Alabama State House. It will mirror our production data center.
- The ISD mainframe supports both TCP/IP and SNA based data communications and has a web site on the Internet.
- TN3270 access is possible via the Internet with the proper security clearances.
- We run both IMS and CICS based transaction subsystems.
- TCP/IP-based File Transfer Protocol (FTP) is the preferred file transfer platform and secure FTP (SFTP) is available.

Medicaid Hardware

Medicaid DO (District Offices) Switches – Cisco Catalyst 3500XL & Cisco Catalyst 3560

Tablet PC LE1700	
Base Unit:	LE1700
Processor:	INTEL CORE 2 DUO 1.5GHz 8
Memory:	1GB RAM
Keyboard:	
Monitor:	
Video Card:	
Hard Drive:	60GB
Floppy Disk Drive:	
Operating System:	
Mouse:	
NIC:	
CD-ROM or DVD-ROM Drive:	
Sound Card:	
Speakers:	

Notebook Latitude D830	
Base Unit:	Latitude D830
Processor:	INTEL CORE 2 DUO T7300 2.0GHz 8 MHZ 4M CACHE DUAL CORE PROCESSOR
Memory:	2GB RAM DDR2-667 SDRAM 2 DIMM
Keyboard:	Internal English
Monitor:	15.4 INCH WIDE SCREEN WXGA
Video Card:	256MB NVIDIA QUADRO NVS
Hard Drive:	80GB 7200 RPM
Floppy Disk Drive:	FLOPPY DRIVE
Operating System:	Windows XP PRO SP2
Mouse:	TOUCHPAD
NIC:	
CD-ROM or DVD-ROM Drive:	8X DVD +/- RW
Sound Card:	
Speakers:	

Desktop Optiplex GX620	
Base Unit:	OptiPlex GX620
Processor:	INTEL P4 620 W/HT 3.2GHz

Memory:	1GB RAM
Keyboard:	Standard
Monitor:	
Video Card:	VIDEO/Graphics – PCIE 256MB CARD, VGA/DVI ADAPTER, DUAL Monitor 128MB
Hard Drive:	160GB 7200 RPM SATA
Floppy Disk Drive:	None
Operating System:	Windows XP PRO
Mouse:	Dell USB 2 Button Optical Mouse with scroll
NIC:	Integrated 10/100/1000 Ethernet
CD-ROM or DVD-ROM Drive:	Optical Drive Combo CD-RW/DVD-ROM
Sound Card:	
Speakers:	Standard Dell

New Desktop Replacements

Optiplex GX760	
Base Unit:	OptiPlex 760 Small Form FactorBase Standard PSU (224-2219)
Processor:	OptiPlex 760,Core 2 Duo E8400/3.0GHz,6M,1333FSB (311-9513)
Memory:	2GB,Non-ECC,800MHz DDR2,2X1GB OptiPlex (311-7374)
Keyboard:	Dell USB Keyboard, No Hot Keys English,Black,Optiplex (330-1987)
Monitor:	No Monitor Selected, OptiPlex (320-3704)
Video Card:	256MB ATI RADEON HD 2400 Pro Single Monitor Graphics w/DVI and TV Out,Low Profile,Dell OptiPlex (320-5740)
Hard Drive:	160GB SATA 3.0Gb/s and 8MB Data Burst Cache, Dell OptiPlex (341-8007)
Floppy Disk Drive:	3.5 inch, 1.44MB, Slimline Floppy Drive,Dell OptiPlex Small Form Factor (341-4611)
Operating System:	Windows XP PRO SP3 with Windows Vista Business License English, Dell Optiplex (420-9570)
Mouse:	Dell USB 2 Button Optical Mouse with Scroll,Black OptiPlex (330-2733)
NIC:	Intel Standard Manageability Hardware Enabled Systems Management, Dell OptiPlex (330-2902)
CD-ROM or DVD-ROM Drive:	Roxio Creator Dell Edidion,9.0Dell OptiPlex (420-7963)
CD-ROM or DVD-ROM	Cyberlink Power DVD 8.1,with Media, Dell

Optiplex GX760	
Drive:	OptiPlex/Precision (420-9179)
CD-ROM or DVD-ROM Drive:	8X DVD+/-RW,Slimline,OptiPlex Small Form Factor (313-6092)
Sound Card:	Heat Sink, Mainstream, Dell Optiplex Small Form Factor (311-9520)
Speakers:	Dell AX210 two piece stereo Speakers (Black) for Latitude OptiPlex, Precision (313-6515)
Cable:	OptiPlex 760 Small Form Factor Standard Power Supply (330-1984)

Storage Area Network: CX4-480	
Base Unit	Dell/EMC CX4-480
System Cache	16 GB
Storage	Current: 28 TB raw storage Expansion Capability: Up to 216 TB raw storage
RAID Levels	RAID 0. 1. 1/0. 3.5. and 6
Number of Supported Hosts	Up to 256 SAN attached HA connected hosts
Connectivity	8Gbit Fiber Channel and 1 Gbit iSCSI

7.10 Appendix J - Responsiveness Requirements Checklist

This appendix identifies the mandatory responsiveness requirements for proposals. Failure, in whole or in part, to respond to a specific mandatory requirement shall result in rejection of the proposal during the evaluation phase.

GENERAL RESPONSE REQUIREMENTS (as defined in ITB Section 4.01)	RESULTS	
	Pass (Yes)	Fail (No)
1. Was the proposal received by the State of Alabama's Department of Finance, Division of Purchasing by the date and time specified in the Section 1.05 - Schedule of Activities?		
2. Was a notarized State of Alabama "Invitation to Bid" form, signed in ink by the Bidder (or an officer of the Bidder who is legally authorized to bind the Bidder to the proposal) submitted as specified in Section 1.10 - Bidder's Submission?		
3. Were one (1) original and ten (10) copies plus two (2) electronic versions of the proposal, with the Transmittal Letter, submitted with at least one (1) copy containing the required original signatures?		
4. Was a Letter of Intent to Bid submitted by the date and time as specified in Section 1.05 - Schedule of Activities?		
5. Was a bid bond guarantee in the amount of three-hundred thousand dollars ($300,000) submitted in the original hard-copy version of the Bid Response, in the required format as specified in Section 1.25 - Bid Guarantee?		

BID RESPONSE REQUIREMENTS (as defined in ITB Section 4.04)	RESULTS	
	Pass (Yes)	Fail (No)
6. Does the Proposal include seven (7) separate sections and assorted subsections, as described in Section 4.04.02: Tab 1A - Transmittal Letter? Tab 1B - Bid Guarantee (Original Volume Only)? Tab 1C – State of Alabama Invitation to Bid Form and Pricing Schedules - Original Volume Only? Tab 2 - Table of Contents? Tab 3 - Executive Summary? Tab 4 - Approach to Implementation Phase? Tab 5 - Operations Phase? Tab 6 - Corporate Capabilities and Commitments? Tab 7 - Appendix?		
7. Is the Transmittal Letter, on official business letterhead, from the entity submitting the proposal as the prime contractor?		
8. Is the Transmittal Letter signed by an individual authorized to legally bind the Bidder?		
9. Does the Transmittal Letter include a statement addressing each of the items in Section 4.03 – Transmittal Letter numbers 1a-q?		
10. If subcontractors are proposed, has each subcontractor submitted a statement, on official letterhead, signed by an individual authorized to legally bind the subcontractor to perform the scope of work, and addressing each of the items in Section 4.03 – Transmittal Letter numbers 2a-e? If subcontractors are not proposed was there a statement to that effect?		
11. Does the Transmittal Letter explicitly identify and explain where the proposal deviates, in any way whatsoever, from the detailed specifications and requirements in the ITB?		

TABLE OF CONTENTS AND ITB CROSS-REFERENCE (as defined in ITB Section 4.04.06)	RESULTS	
	Pass (Yes)	Fail (No)
12. Is there a Table of Contents with the titles for each section and beginning page numbers?		
EXECUTIVE SUMMARY (as defined in ITB Section 4.04.07)		
13. Is the Executive Summary no more than twenty-five (25) pages in length?		
APPROACH TO IMPLEMENTATION PHASE (as defined in ITB Section 4.04.08)		
14. For each of the six (6) components identified in Section 4.04.08, has the Bidder provided the required information in the order and format specified? • Design and Development Methodology • Products and Deliverables • Implementation Phase and Work Plan • Proposed Staffing • Implementation Phase Contract Management • Commitment to Quality		
APPROACH TO OPERATIONS PHASE) (as defined in ITB Section 4.04.09)		
15. Does the Bidder include a staffing approach for the Operations Phase?		
CORPORATE CAPABILITIES AND COMMITMENTS (as defined in ITB Section 4.04.10)		
16. Is the Corporate Capabilities and Commitments section no more than forty (40) pages long, exclusive of financial statements? And does it contain Corporate Information, Financial Statements, Contractual Disputes and Corporate Commitments?		
17. Did the Bidder complete Appendix L – Business Experience Matrix with a minimum of three (3) references of previous contracts in which the Bidder processed medical claims included in the proposal?		
18. Has the Bidder submitted financial statements?		
PRICING SCHEDULES (as defined in ITB Section 4.04.05)		
19. Is there a signed and completed Pricing Schedule A(I) or A(N)?		
20. Is there a signed and completed Pricing Schedule B(I) or B(N)?		
21. Is there a signed and completed Pricing Schedule C(I) or C(N)?		
22. Is there a signed and completed Pricing Schedule D(I) or D(N)?		
23. Are all the calculations shown on the various pricing schedules accurate?		

7.11 Appendix K - AMMIS Deliverables

- All MMIS software to which Medicaid has ownership, or which has been designed, developed, or installed with federal matching funds, on CD/DVD.

- All production and test data files used in running the MMIS on CD/DVD.

- All imaged documents stored on optical and magnetic disk, including any documents to be purged and a backup copy of the current file(s).

- Job scripts and scheduling information for every production job to include, at a minimum, condition codes, system messages, start and stop dates and times, CPU time used, and clock time on CD/DVD in a format specified by the Agency.

- All other documentation, on CD/DVD, including, but not limited to, user and operation manuals needed to operate and maintain the system.

- Operations logs, process summaries, and balancing documents completed during the contract, in a medium and format specified by the Agency.

- Procedures for updating computer programs, scripts, data dictionaries, and other documentation.

- Job scheduling parameters and/or inputs and reports used by operations staff during routine operations.

- Hardware configuration diagram showing the relationship between all information systems and communication equipment necessary to operate the AMMIS, including, but not limited to: local area networks, EMC support networks, control units, remote job entry devices, data storage and transmission devices, printers, computers, PCs, and data entry devices.

- A description and flow charts showing the flow of major processes and data in each of the MMIS subsystems and across subsystems. This will include but not be limited to a data flow diagram showing data stores and flows.

- Claims that are used for regression testing and to test data entry.

- Data Element Dictionary of all AMMIS tables, attributes and Meta data.

7.12 Appendix L - Business Experience Matrix

NOTE: MS Excel Worksheet will be provided separately at the Pre-Bid Conference.

7.13 Appendix M - Cost Containment Proposal

7.13.01 Cost Containment

The Agency offers the Vendor the opportunity to participate in the management of Agency expenditures during the contract period. The Vendor may propose new and creative ideas for increasing Agency control over the expenditure of program dollars. If accepted and implemented by Agency during the Operations Period, payment shall be made after savings are actually realized. This does not include operational or administrative savings.

7.13.02 Cost Containment Innovations

Throughout the life of this Contract, the Vendor shall propose new and creative ideas that increase the Agency's control over the expenditure of program dollars and result in a savings in Agency program expenditures. The Vendor shall create a unit whose sole function is to work on cost containment proposals and projects. This unit shall be staffed with medical, analytical, statistical, and clerical data processing support staff that shall be provided with necessary computers and administrative support. This unit shall remain in existence for the life of this Contract.

The Vendor shall analyze program expenditures and processing controls, develop new and creative approaches to controlling expenditures, and present those proposals to the Agency.

The Agency, however, retains the sole right of approval of each cost containment proposal and any Agency-approved reductions in expenditures related to fraud, as well as the cost savings methodology on a project-by-project basis throughout the life of the contract. The Agency is not mandated to approve any of the proposed projects. Furthermore, the Agency reserves the sole right to discontinue, by letter, any previously approved project at any time.

Any proposals that are counter to law or regulation will not be accepted. In addition, the Agency will not accept any proposals which, in its sole discretion, are not in the best interests of the Agency, or are not feasible.

Cost Containment innovations that are modifications to an implemented System Development Notice (SDN) design will not be approved.

Cost Containment staff shall be the sole responsibility of the Vendor and not be included under any Agency expense. Cost Containment Staff shall not utilize and/or share responsibilities with other Vendor staff as described elsewhere in this Contract.

7.13.03 Proposals

Once the Agency has accepted a cost-containment proposal the Vendor shall submit to the Agency a suggested methodology for determining the actual savings the proposal will

generate. The Vendor shall submit the methodology to the Agency for review and approval no more than fourteen (14) months from the date the changes were implemented. The Agency shall have sixty (60) calendar days from receipt of the methodology for review and approval. If the Agency does not agree with the suggested methodology, and no agreement can be reached with the Vendor, the Commissioner shall determine the method to be used. Once the methodology is mutually agreed to or determined by the Commissioner, it shall not be subject to dispute.

Payment to the Vendor for implemented cost-containment proposals and/or any reductions in expenditures related to fraud shall be made only after savings are actually realized. The Vendor shall develop reports and submit them to the Agency showing the savings as determined by the established methodology.

7.13.04 Systems Development

The installation of each cost containment proposal shall be initiated through normal change procedures using **change orders written (COWs)**. All cost containment projects requiring programming and/or system updates shall be done by Vendor resources with prior Agency approval. If done by Vendor resources, the Vendor's change order process shall be followed and the results shall become part of the AMMIS. The Vendor costs for the implementation of cost containment proposals shall be considered as billable hours to the Agency at fifty percent (50%) of the bid rate.

If any time after the changes are implemented the Agency should find it necessary to rescind the change or modify the effective date and this change results in the need to reprocess claims previously denied or cutback under the change, the Vendor shall prepare a new methodology and determine the updated savings amounts. The new savings shall be compared to the original savings amounts and a credit issued to the Agency. The cost of system changes shared with the Vendor shall be refunded to Agency if no savings are realized to cover the actual systems cost.

7.13.05 Operations: Cost Containment

Operations constitute all contractual responsibilities required for the Vendor to administer and operate the AMMIS as described in this ITB.

The activities of the Cost Containment Project are non-billable.

When a cost containment proposal is implemented by the Vendor, the Vendor will be paid an administrative fee for that proposal for a period not to exceed two (2) years from the date of implementation. Additionally, the Vendor's costs for implementation of cost containment proposals through the process shall be considered as billable hours to the Agency at fifty percent (50%) of the bid rate.

7.13.05.01 Cost Containment Payment

The payment for Agency approved cost containment projects is based on the Vendor receiving an administrative fee equal to ten percent (10%) of the amount of net program

dollars saved (the actual amount of program dollars saved less development costs) from all projects up to that time.

The payment for billable hours for programming and/or system updates of cost containment proposals shall be at fifty percent (50%) of the hourly rate. The Vendor must show 100% of the hours on the invoice for the project, with fifty (50%) of the hours shown as non-billable. The Vendor shall not submit invoices for any costs related to a cost containment project until such time as the actual net savings are realized as a result of the implementation exceed the total costs incurred by the Vendor. The Vendor must provide sufficient documentation at the time the invoice is submitted to prove the actual savings realized meets or exceeds the total costs for the project. This portion of the invoice will be paid only upon the Contracting Officer's approval of such documentation.

7.13.05.02 Cost Containment Invoicing

Two (2) months after the implementation of each proposal, and monthly thereafter, the Vendor will send a report to the Agency that shows the monthly savings from each cost containment project, and the total monthly savings and total cumulative savings from all cost containment projects that have been implemented within the last two years and are still in operation. The Vendor will invoice the State for ten percent (10%) of the cumulative amount reflected in the reconciled saving report for the month in which the savings exceed two hundred and fifty thousand dollars ($250,000). The Agency will reconcile the invoice and pay the Vendor the full amount earned. **When another $250,000 program dollars** are saved from all projects, the Vendor will invoice again and be paid ten percent (10%) of that cumulative amount reflected in the monthly reconciled savings report for the month in which the savings exceed $250,000. Payment in this manner will continue, except as defined below.

7.13.05.03 End of Contract Payment Adjustments

For those projects implemented in the last two (2) years of contract operations, including any contract extensions and/or the two (2) years prior to a contract termination, the administrative fee shall be adjusted on a pro rated basis so the Vendor will receive a total administrative fee for the project equal to that which the Vendor would have received had the Vendor been able to operate the project for the full two (2) years allowed. In no instance shall the Agency pay a prorated administration fee if the Contract is terminated for cause. In this instance the Vendor shall submit an invoice for ten percent (10%) of the actual savings realized prior to the date of termination.

7.13.05.04 Precedent for Payment

The Agency must approve cost containment proposals, including estimated savings formulas, before the Vendor may commence work. Under no circumstances will the Agency pay the Vendor for savings that result from a cost containment proposal that was not first approved by the Contracting Officer.

7.13.06 Opportunities for Reduction in Operations Costs

The Vendor is encouraged to submit proposals which reduce the operations cost of the AMMIS Contract. These proposals shall be known as Cost Reduction Change Proposals. If approved, a Vendor-initiated proposal will result in a shared savings between the Vendor and the Agency. This Section describes Operations Payment for any work that may occur during Operations due to cost containment activities.

7.13.06.01 Cost Reduction Change Proposal Projects

1. Proposals Related to System Operations -

   When a Cost Reduction Change Proposal Project that affects system operations is implemented by the State, the Vendor will be paid a percentage of the net contract savings according to the percentages set forth below.

   a. If a Cost Reduction Change Proposal is Vendor initiated, net contract savings shall be apportioned seventy-five percent (75%) to the Vendor and twenty-five percent (25%) to Agency. The twenty-five percent (25%) savings shall be applied under Contractor Amendment costs, or, if there are no offsetting changes, the apportioned savings will result in a reduction in contract prices.

   b. If a Cost Reduction Change Proposal results from joint efforts on the part of Agency and the Vendor, net contract savings shall be proportionately shared between the parties, the proportioned shares to be determined through an agreement of the parties. In the event that an agreement on proportioned shares cannot be reached within six (6) months of the date the Agency authorizes the change, the Agency and the Vendor shall each share fifty percent (50%) of the benefits.

2. Proposals Related to Cost Reimbursed Items:

   For Cost Reduction Change Proposals that affect the cost reimbursement portion of the Contract, regardless of whether it was originated by the Vendor or resulted from joint efforts on the part of Agency and the Vendor, net contract savings shall be apportioned between Agency and the Vendor as follows:

Cumulative Savings	Agency Share	Vendor Share
$5,000 - $250,000	50%	50%
$250,001 and above	Percent apportionment negotiable but shall not exceed 50% to the Vendor and shall not exceed a maximum of $500,000 per improvement to the Vendor.	

3. Proposals Originated and Paid for by Agency:

For system improvements originated and paid for by Agency which decreases the operating expenses or costs, or result in one-time decreased expense or cost, the financial benefits of those changes shall be one hundred percent (100%) to Agency and will result in a reduction of the cost or price of the Contract.

Agency costs shall be offset against the savings generated by the Cost Reduction Change Proposal each time such savings are realized until all costs are fully offset. Then, the Vendor's share is calculated by multiplying net contract savings by the appropriate Vendor's percentage-sharing rate). Additional Vendor shares of net contract savings shall be paid to the Vendor at the time savings are realized until the Vendor's share is fully realized.

Documentation of contract savings is the responsibility of the Vendor and is subject to Contracting Officer review and approval prior to payment of the Vendor's share of cost savings as allocated using the apportionment methodology described above. The Vendor will submit a monthly cost savings invoice with appropriate documentation to Agency. The Agency must approve the documentation submitted before payment of the invoice is made. For one-time cost savings, the Vendor will submit a single invoice

7.14 Appendix N - Medicaid Business Associate Addendum

(SAMPLE)

ALABAMA MEDICAID AGENCY
BUSINESS ASSOCIATE ADDENDUM

This Business Associate Addendum (this "Agreement") is made effective the _____ day of _____, 20____, by and between the Alabama Medicaid Agency ("Covered Entity"), an agency of the State of Alabama, and _____ ("Business Associate") (collectively the "Parties").

1. BACKGROUND

a. Covered Entity and Business Associate are parties to a contract entitled _____ (the "Contract"), whereby Business Associate agrees to perform certain services for or on behalf of Covered Entity.

b. The relationship between Covered Entity and Business Associate is such that the Parties believe Business Associate is or may be a "business associate" within the meaning of the HIPAA Privacy Rule (as defined below).

c. The Parties enter into this Business Associate Addendum to the Contract with the intention of complying with the HIPAA Privacy Rule provision that a covered entity may disclose protected health information to a business associate, and may allow a business associate to create or receive protected health information on its behalf, if the covered entity obtains satisfactory assurances that the business associate will appropriately safeguard the information.

2. DEFINITIONS

Unless otherwise clearly indicated by the context, the following terms shall have the following meaning in this Agreement:

a. "Breach" shall mean the acquisition, access, use or disclosure of protected health information which compromises the security or privacy of such information, except where an unauthorized person to whom such information is disclosed would not reasonably have been able to retain such information.

b. "Electronic Health Record" shall mean an electronic record of health-related information on an individual that is created, gathered, managed, and consulted by authorized health care clinicians and staff.

c. "Electronic Protected Health Information" means Protected Health Information that is transmitted by Electronic Media (as defined in the Security and Privacy Rule) or maintained in Electronic Media.

d. "HIPAA" means the Administrative Simplification Provisions, Sections 261 through 264, of the federal Health Insurance Portability and Accountability Act of 1996, Public Law 104-191.

e. "Individual" shall have the same meaning as the term "individual" in 45 CFR 164.501 and shall include a person who qualifies as a personal representative in accordance with 45 CFR 164.502(g).

f. "Personal Health Record" shall mean an electronic record of identifiable health information on an individual that can be drawn from multiple sources and that is managed, shared and controlled by or primarily for the individual.

g. "Privacy Rule" shall mean the Standards for Privacy of Individually Identifiable Health Information at 45 CFR part 160 and part 164, subparts A and E.

h. "Protected Health Information" (PHI) shall have the same meaning as the term "protected health information" in 45 CFR 164.501, limited to the information created or received by Business Associate from or on behalf of Covered Entity.

i. "Required By Law" shall have the same meaning as the term "required by law" in 45 CFR 164.501.

j. "Secretary" shall mean the Secretary of the United States Department of Health and Human Services or his designee.

k. "Security Incident" shall mean the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with system operations in an information system.

l. "Security Rule" shall mean the Security Standards for the Protection of Electronic Protected Health Information at 45 CFR Parts 160 and 162, and Parts 164, Subparts A and C. The application of Security provisions Sections 164.308; 164.310, 164.312, and 164.316 of title 45, Code of Federal Regulations shall apply to a business associate of a covered entity in the same manner that such sections apply to the covered entity.

m. Unless otherwise defined in this Agreement, capitalized terms used herein shall have the same meaning as those terms have in the Privacy Rule.

n. "Unsecured Protected Health Information" is information that is not rendered unusable, unreadable, or indecipherable to unauthorized individuals by mean of technology or methodology specified by the Secretary of Health and Human Services in the guidance issued under section 13402(h)(2) of Public Law 111–5.

3. OBLIGATIONS OF BUSINESS ASSOCIATE

a. Use and Disclosure of PHI. Business Associate agrees to not use or disclose PHI other than as permitted or required by this Agreement or as Required By Law.

b. Appropriate Safeguards. Business Associate agrees to use appropriate safeguards to prevent use or disclosure of the PHI other than as provided for by this Agreement. The Business Associate agrees to take steps to safeguard, implement and maintain PHI in accordance with the HIPAA Privacy Rule.

c. Mitigation. Business Associate agrees to mitigate, to the extent practicable, any harmful effect that is known to Business Associate of a use or disclosure of PHI by Business Associate in violation of the requirements of this Agreement.

d. Report Unauthorized Use or Disclosure. Business Associate agrees to promptly report to Covered Entity any use or disclosure of PHI not provided for by this Agreement of which it becomes aware.

e. Applicability to Business Associate's Agents. Business Associate agrees to ensure that any agent, including a subcontractor, to whom it provides PHI received from, or created or received by the Business Associate on behalf of, Covered Entity agrees to the same restrictions and conditions that apply through this Agreement to Business Associate with respect to such information. The Business Associate agrees to have HIPAA-compliant Business Associate Agreements or equivalent contractual agreements with agents to whom the Business Associate discloses Covered Entity PHI.

f. Access. Upon receipt of a written request from Covered Entity, Business Associate agrees to provide Covered Entity, in order to allow Covered Entity to meet its requirements under 45 CFR 164.524, access to PHI maintained by Business Associate in a Designated Record Set within thirty (30) business days.

g. Amendments to PHI. Business Associate agrees to make any amendment(s) to PHI maintained by Business Associate in a Designated Record Set that Covered Entity directs or agrees to, pursuant to 45 CFR 164.526 at the request of Covered Entity, within thirty (30) calendar days after receiving a written request for amendment from Covered Entity.

h. Availability of Documents. Business Associate agrees to make internal practices, books, and records, including policies and procedures and PHI, relating to the use and disclosure of PHI received from, or created or received by the Business Associate on behalf of, Covered Entity, available to Covered Entity or to the Secretary for purposes of the Secretary determining Covered Entity's compliance with the Privacy and Security Rules, within five business days' after receipt of written notice.

i. Documentation of PHI Disclosures. Business Associate agrees to keep records of disclosures of PHI and information related to such disclosures as would be required for Covered Entity to respond to a request by an individual for an accounting of disclosures of PHI in accordance with 45 CFR 164.528.

j. Accounting of Disclosures. The Business Associate agrees to provide to Covered Entity, within 30 days of receipt of a written request from Covered Entity, information collected in accordance with the documentation of PHI disclosure of this Agreement, to permit Covered Entity to respond to a request by an Individual or an authorized representative for an accounting of disclosures of PHI in accordance with 45 CFR 164.528.

k. The Business Associate shall maintain a comprehensive security program appropriate to the size and complexity of the Business Associate's operations and the nature and scope of its activities as defined in the Security Rule.

l. The Business Associate shall notify the Covered Entity immediately following the discovery of a breach of Protected Health Information (PHI).

m. The Business Associate shall provide the Covered Entity the following information when a breach of unsecured protected health information is discovered:

1. The number of recipient records involved in the breach.
2. A description of what happened, including the date of the breach and the date of the discovery of the breach if known.
3. A description of the types of unsecure protected health information that were involved in the breach (such as whether full name, social security number, date of birth, home address, account number, diagnosis, disability code, or other type information were involved).
4. Any steps the individuals should take to protect themselves from potential harm resulting from the breach.
5. A description of what the Business Associate is doing to investigate the breach, to mitigate harm to individuals and to protect against any further breaches.
6. Contact procedures for individuals to ask questions or learn additional information, which shall include the Business Associate's toll-free number, email address, Web site, or postal address.
7. A proposed media release developed by the Business Associate.

n. The Business Associate shall obtain Covered Entity approval prior to reporting any breach required by 45 CFR Part 164, Subpart D.

o. The Business Associate shall, after receiving Covered Entity approval, provide the necessary notices to the recipient, prominent media outlet, or the Secretary of Health and Human Services (HHS) to report Business Associate breaches as required by 45 CFR Part 164, Subpart D.

p. Covered Entity will coordinate with the Business Associate in the determination of additional specific actions that will be required of the Business Associate for mitigation of the breach.

q. If the Business Associate is a vendor of personal health records, notification of the breach will need to be made with the Federal Trade Commission.

r. The Business Associate shall be responsible for any and all costs associated with the notification and mitigation of a breach that has occurred because of the negligence of the Business Associate.

s. The Business Associate shall pay all fines or penalties imposed by HHS under 45 CFR Part 160 HIPAA Administrative Simplification: Enforcement rule for breaches made by any employee, officer, or agent of the Business Associate.

t. The Business Associate shall be subject to prosecution by the Department of Justice for criminal violations of HIPAA if the Business Associate obtains or discloses individually identifiable health information without authorization, and shall be responsible for any and all costs associated with prosecution.

4. PERMITTED USES AND DISCLOSURES

Except as otherwise limited in this Agreement, if the Contract permits, Business Associate may use or disclose PHI to perform functions, activities, or services for, or on behalf of, Covered Entity as specified in the Contract, provided that such use or disclosure would not violate the Privacy Rule if done by Covered Entity;

a. Except as otherwise limited in this Agreement, if the Contract permits, Business Associate may use PHI for the proper management and administration of the Business Associate or to carry out the legal responsibilities of the Business Associate.

b. Except as otherwise limited in this Agreement, if the Contract permits, Business Associate may disclose PHI for the proper management and administration of the Business Associate, provided that:

   1. disclosures are Required By Law; or

   2. Business Associate obtains reasonable assurances from the person to whom the information is disclosed that it will remain confidential and used or further disclosed only as Required By Law or for the purpose for which it was disclosed to the person, and the person notifies the Business Associate of any instances of which it is aware in which the confidentiality of the information has been breached.

c. Except as otherwise limited in this Agreement, if the Contract permits, Business Associate may use PHI to provide data aggregation services to Covered Entity as permitted by 42 CFR 164.504(e)(2)(i)(B).

d. Notwithstanding the foregoing provisions, Business Associate may not use or disclose PHI if the use or disclosure would violate any term of the Contract.

5. REPORTING IMPROPER USE OR DISCLOSURE

a. The Business Associate shall report to the Covered Entity any use or disclosure of PHI not provided for by this agreement immediately from the time the Business Associate becomes aware of the use or disclosure.

b. The Business Associate shall report to the Covered Entity any Security Incident and/or breach immediately from the time the Business Associate becomes aware of the use or disclosure.

6. OBLIGATIONS OF COVERED ENTITY

a. Covered Entity shall notify the Business Associate of any limitation(s) in its notice of privacy practices in accordance with 45 CFR 164.520, to the extent that such limitation may affect Alabama Medicaid's use or disclosure of PHI.

b. Covered Entity shall notify the Business Associate of any changes in, or revocation of, permission by an Individual to use or disclose PHI, to the extent that such changes may affect the Business Associate's use or disclosure of PHI.

c. Covered Entity shall notify the Business Associate of any restriction to the use or disclosure of PHI that Covered Entity has agreed to in accordance with 45 CFR

164.522, to the extent that such restriction may affect the Business Associate's use or disclosure of PHI.

d. Covered Entity shall not request Business Associate to use or disclose PHI in any manner that would not be permissible under the Privacy Rule if done by Covered Entity.

e. Covered Entity shall provide Business Associate with only that PHI which is minimally necessary for Business Associate to provide the services.

7. TERM AND TERMINATION

a. **Term**. The Term of this Agreement shall be effective as of the effective date stated above and shall terminate when the Contract terminates.

b. **Termination for Cause**. Upon Covered Entity's knowledge of a material breach by Business Associate, Covered Entity may, at its option:

1. Provide an opportunity for Business Associate to cure the breach or end the violation, and terminate this Agreement if Business Associate does not cure the breach or end the violation within the time specified by Covered Entity;

2. Immediately terminate this Agreement; or

3. If neither termination nor cure is feasible, report the violation to the Secretary as provided in the Privacy Rule.

c. **Effect of Termination**.

1. Except as provided in paragraph (2) of this section or in the Contract, upon termination of this Agreement, for any reason, Business Associate shall return or destroy all PHI received from Covered Entity, or created or received by Business Associate on behalf of Covered Entity. This provision shall apply to PHI that is in the possession of subcontractors or agents of Business Associate. Business Associate shall retain no copies of the PHI.

2. In the event that Business Associate determines that returning or destroying the PHI is not feasible, Business Associate shall provide to Covered Entity notification of the conditions that make return or destruction not feasible. Business Associate shall extend the protections of this Agreement to such PHI and limit further uses and disclosures of such PHI to those purposes that make the return or destruction infeasible, for so long as Business Associate maintains such PHI.

7. GENERAL TERMS AND CONDITIONS

a. This Agreement amends and is part of the Contract.

b. Except as provided in this Agreement, all terms and conditions of the Contract shall remain in force and shall apply to this Agreement as if set forth fully herein.

c. In the event of a conflict in terms between this Agreement and the Contract, the interpretation that is in accordance with the Privacy Rule shall prevail. Any ambiguity in this Agreement shall be resolved to permit Covered Entity to comply with the Privacy Rule.

d. A breach of this Agreement by Business Associate shall be considered sufficient basis for Covered Entity to terminate the Contract for cause.

e. The Parties agree to take such action as is necessary to amend this Agreement from time to time for Covered Entity to comply with the requirements of the Privacy Rule and HIPAA.

IN WITNESS WHEREOF, Covered Entity and Business Associate have executed this Agreement effective on the date as stated above.

ALABAMA MEDICAID AGENCY

Signature: _____

Printed Name: **Paul Brannan**

Title: Privacy Officer

Date: _____

BUSINESS ASSOCIATE

Signature: _____

Printed Name: _____

Title: _____

Date: _____

7.15 Appendix O - Alabama Medicaid 2011 MMIS Procurement Quality Assurance Plan

(The following pages in Appendix O are extracts from the Alabama Medicaid 2011 MMIS Procurement Quality Assurance Plan. A complete copy of the plan can be found in the Procurement Library)

PROJECT OVERVIEW

The 2011 MMIS (Medicaid Management Information System) Procurement project has been tasked with planning for the next MMIS fiscal agency contract and possible MMIS take-over for the Alabama Medicaid Agency. The project started in January 2009 with five team members. The project charter was developed and signed by the end of February 2009.

The 2011 MMIS Procurement project has identified the following major deliverables as requirements, an APD (Advanced Planning Document), and an ITB (Invitation to Bid). The ITB will identify additional deliverables required of the selected bidder. When we complete the ITB, we will help the Agency prepare for the review and evaluation of the vendor proposals. The evaluation of the proposals will determine the vendor selected and enable us to prepare for the MMIS enhancements or take-over with enhancements.

PROJECT QA PLAN PURPOSE

The purpose of this QA (Quality Assurance) Plan is to define the techniques, procedures, and methodologies to be used on the 2011 MMIS Procurement Project. Our ultimate goal is timely delivery of the product that meets the client requirements within project or contract resources. This document provides the methodology and criteria we will use to help ensure that all work is consistent, traceable, and of a high standard.
The goal of our quality assurance plan is to ensure that processes and standards are followed. The use of processes and standards help ensure all products delivered meet all technical requirements and the desired level of quality. The QA procedures defined in this document shall be used to examine all products to determine compliance with processes, procedures, and standards established for the 2011 MMIS Procurement Project.

The 2011 MMIS Procurement project rates quality as the #2 priority in the project. The #1 priority is functionality. We will go the extra step to ensure that our project produces quality products and that the products define the functions requested by the Agency. Note: In this document all documents/deliverable/products will be referred to as a product. The ‘product’ tag does not lessen the importance of any document or deliverable.

QUALITY ASSURANCE METHODOLOGY

In order to accomplish our goals in quality this document will define process and procedures for the QA team. These process and procedures will be streamlined or expanded as necessary to ensure we produce the highest quality work possible. This

document will be a "living" document that is modified throughout the project to reflect the changes or additions that we make to the QA methodology. We (the QA team) must follow the same guidelines that we request others in the project to follow.

We began our journey toward quality with a process for gathering requirements. The original process was quickly modified due to time constraints in the schedule. The process was streamlined and a revised version posted to our document repository SharePoint.

SharePoint is the Agency's document repository. SharePoint provides the capability to retain an infinite number of versions for each document with the creator/modifier name and date for each version. The versioning accommodates drafts, baselines, major and minor releases. This project will require all versions of a document to be retained as well as operator/user making the change and a date and time stamp for the change.

PROJECT QUALITY ASSURANCE

Our quality assurance activities will focus on project monitoring, document versioning, monitoring meetings and traceability. The quality assurance activities will monitor the overall quality in the project. It will be used to monitor communication, follow-through and the processes or procedures used to create products.

PROJECT MONITORING

Project start-up documents and milestone deliverables (such as plans) will be reviewed periodically to verify the document reflects the current state of the project. If the document differs from the state of the project, a QA issue will be opened in the project tracking system. The owner of the document shall be given 10 days to update the product and obtain Agency approval. Once Agency approval is received the QA issue will be updated with the resolution and the issue will be closed (see Quality Issue Tracking for more information). Each product shall have a section that defines how the product will be monitored to ensure defined processes and procedures are followed. The project plans shall be reviewed quarterly to ensure the information is current. The project schedule and other products with constantly changing information shall be reviewed monthly. Any member of the QA team may review a product or request changes/updates to a product at any time. This will allow us to identify changes as they occur and request the product be modified to reflect the project change.

DOCUMENT VERSIONING

SharePoint is the Agency's document repository. SharePoint provides the capability to retain an infinite number of versions for each document with the creator/modifier name and date for each version. The versioning accommodates drafts, baselines, major and minor releases. This project will require all versions of a document be retained. The draft documents (documents that have not received Agency approval) will use a numbering below 1 (V0.75). Once the document has been accepted by the agency the document will become version 1.0. All future changes to the document will be

incremented by .01 until a major change is made to a section in the document. All major changes will increment the version by 1.0. The document must also contain a revision history which follows the Table of Contents within the document. The change history will include date, version, name of person making change, reason for change and sections or pages modified. A QA issue will be opened for all versioning problems. When the problem is corrected, the QA team member will update the QA issue with the resolution and close it.

MONITOR MEETINGS

The QA lead shall be notified at least one business day in advance of all meetings, reviews, work sessions, etc. that pertain to the project. The QA lead or team member will randomly monitor meetings and work sessions. Some of the criteria the QA team will use to review the meeting or work session will include:

- Meeting Structure (suggested structure includes):
    - Agenda
    - Roll call
    - Parking lot
    - Action items
    - Meeting notes
- Meeting productivity (i.e. progress made compared with the man hours expended)
- Meeting findings or observations
- QA action items

The QA team member will complete a one page Meeting Review form for each meeting attended. The meeting review documents will be stored in a folder in SharePoint. The QA lead shall monitor the meeting reviews to ensure the QA action items are complete. This information shall be used in the Quarterly QA report.

The QA action items will be used to identify information that needs to be checked or validated or information that should be shared with the team or another functional area. This will include such things as:

- Verification or review of requirements
- Verification or review of plans
- Information to be shared with other functional areas or team members.
- Questions for meeting facilitator or Agency that need to be handled off-line

The QA team member will open a QA issue for all QA action items identified in the Meeting Review. The issue will be closed with the action item has been completed

TRACEABILITY

A Requirements Traceability Matrix (RTM) will be used to address traceability with the ITB as the originating document. The RTM will follow the requirement from the ITB

through gap analysis, design, development, testing and production. The reverse is also true, the RTM will trace the requirement from production to testing, development, design, gap analysis and back to the requirement in the ITB. The QA team shall validate traceability throughout the project. A QA team member will open a QA issue for all traceability problems identified. The issue will be updated with the resolution and closed when the traceability item has been corrected

QUALITY ISSUE TRACKING

The QA team will use the project issue tracking system to track all issues identified in our reviews. The issue tracking system shall have a method to identify issues directly related to quality. All open quality issues will be reported in the QA quarterly report. If there are quality issues identified before the project issue tracking standards have been established, the team will use an issue tracking spreadsheet located in the SharePoint QA folder. See QA Issue Tracking spreadsheet for an example. If the spreadsheet is used, the open issues will be transferred to the project issue tracking software once it is determined & available.

PROJECT QUALITY CONTROL

Quality control activities are performed throughout the project to verify that project management and the project processes defined in the deliverables are properly maintained, of high quality and meet quality standards. Quality control will use deliverable definition documents, project monitoring and a Quarterly QA Assessment report to accomplish these goals.

DELIVERABLE DEFINITIONS

As part of the project startup, we will require deliverable definition (DD) documents. These documents will contain an outline of the final document with descriptive information for each section of the document. The DD must be approved by the appropriate Agency staff. The DD will provide a better understanding to the Agency and the submitter of the document purpose and content. Each product submitted will be compared to the DD for that product. If the product does not follow the approved DD the product will be immediately rejected. See the Product Rejection section for more information.

QUARTERLY QA ASSESSMENT REPORT

The QA lead will produce a quarterly QA Assessment Report by the 7th business day of the month following quarter end. The report will identify the QA activities for the quarter. It will contain a summary of meeting reviews and an assessment of the projects focus on quality. Other items will be added to the report as identified or requested. See the Quarterly QA Report Deliverable Definition for an example.

PROJECT AUDITS AND QUALITY REVIEWS

The QA team will use audits and reviews to help ensure the quality of the products. The audits will verify the defined process is being followed. The reviews will be used to verify the quality of the product.

PROJECT/PRODUCT AUDITS

The audits will be conducted at least quarterly. The Project Manager or QA lead can request an audit at any time or an audit can be triggered by poor quality products. The goal of the audit is to eliminate rework by finding the root cause of the problem. The root cause may be the project documents, a poor process, a lack of understanding the process or even the creator or reviewer. The QA team auditor shall produce a report for the Project Manager and QA Lead. The report may suggest or necessitate follow-up actions. See Audit Report for example.

All members of the QA team will perform audits. The first audit performed by a team member shall have an experienced member, such as the QA lead, participate in the audit. The responsibility for the audit shall rotate unless a problem area is identified for continuous monitoring. The continuous monitoring assignment shall be made by the PM based on workload. Continuous monitoring will require a QA team member at all meetings, reviews, work sessions, etc. for the specific area identified. The QA member responsible for the continuous monitoring of an area shall produce a weekly report of their findings. The report shall be based on the meeting review form.

PRODUCT REJECTION

When a product is first received by the Agency it shall have a very high level review (a rejection review) before it is passed along to the FPO's/PAC's (Functional Process Owners/Program Area Coordinators) or MMIS core team members. The criteria in the table below will result in immediate rejection of the product submitted. Any comments noted to that point will be returned to the submitter as well as the reason for rejection. If the product passes the product rejection criteria identified below, it will be accepted for review. A product rejected twice (not reviewed, but rejected) shall require a minimum of a 5 day wait before being submitted again – even if this results in the product being delivered late. A product rejected three times or more will be escalated to the PM for possible discussion with the Review Board.

PRODUCT REJECTION CRITERIA

Rejection	Rejection Criteria
Immediate Rejection with one comment only (to identify the error)	Misspelling Another state's name in the product (including properties) Missing submission documentation (review checklist, signatures, etc.)

Rejection	Rejection Criteria
	Product does not follow DD (deliverable definition document) Format problems (TOC not updated page numbers off, etc.) Versioning incorrect (version number is missing or incorrect, product history is not updated or correct, track changes is not available (WORD documents only - Original submission shall have track changes turned on).
Rejection on 1st occurrence with only comments to that point.	Information from another state (does not apply to Alabama) that does not contain the state name. Information from the previous version of the product that is no longer applicable. Missing data (a notation that something needs follow-up, question marks or any other special indicator that data is missing) More than 10 unique comments (the same comment in 10 places will only count as 1 comment)

QUALITY REVIEWS

The Agency shall conduct quality reviews on all products delivered. The deliverables identified in the project plan or any product requested by the Agency will have a group review. Normal deliverables and second reviews (when necessary) will be handled as individual reviews. All products must pass the rejection review before it will be considered for an individual review or a group review. All products submitted for review shall include a review check-list which contains the criteria used to review the product and signatures of all reviewers.

AGENCY STAFF INDIVIDUAL PRODUCT REVIEW

Once the product passes the rejection review, it will be available for Agency staff to review. The documentation manager will identify the product reviewers (the Agency staff requested to review the product). The reviewers will be sent an e-mail notification of the review and if available, a SharePoint workflow will be started. The product to review and an Agency Review Comments (ARC) log will be available in SharePoint. The e-mail and the workflow, if available, will specify the due date for the review. The initial review of a product will be allowed 5-10 business days. The day of submission to

the Agency and return to the vendor will not be included in the review period. The submitter will have the same amount of time to respond to the comments. The follow-up review and response, if required, will be 5 to 7 business days depending on the size of the product. All comments must be closed with the second response. If any comment remains open, a meeting will be scheduled as soon as possible but within 5 days of receipt of the follow-up response. See Agency Review Comments (ARC) for a sample comment log.

AGENCY STAFF GROUP PRODUCT REVIEW

The major milestone deliverables defined in the project plan or any product identified by the Agency shall receive a group product review. This review will occur as a meeting with all applicable Agency staff in attendance. The product will be submitted to the Agency 5 working days before the meeting along with a request for the meeting. The Agency Staff will review the product prior to the meeting and note any comments or concerns. If an Agency invitee cannot or will not attend the meeting, their comments can be presented by a co-worker. If the Agency invitee does not attend or send a co-worker they must reject the meeting or e-mail the meeting coordinator or a designated person, stating they have no comments and approve the product as is. If the Agency invitee or a co-worker cannot attend, but they do have comments on the product these comments can be submitted to the Document Manager or a designated person. The Documentation Manager or designated person will represent the FPO/PAC at the group review meeting. The deliverable or product will be reviewed and modified in a meeting with the result of the meeting being an approved product or deliverable. If approval cannot be obtained during the meeting the meeting facilitator shall assign action items and tentatively schedule a follow-up meeting. The follow-up meeting shall occur within 5 days of the original meeting. If the Agency will still not approve the product during the 2nd meeting, the submitter must take a minimum of 5 days to review the product before rescheduling a review.

QUALITY TEAM ROLES

The table below identifies the roles and responsibilities of the 2011 MMIS core team. The roles and responsibilities of other members shall be defined as they join the project.

ROLES AND RESPONSIBILITIES TABLE

Role	***Responsibilities***
Project Manager Paul Brannan	Review all deliverable definition documents Review all products
Quality Lead Renee LaRosa	Review all deliverable definition documents Review all products Schedule & facilitate all quality review sessions (unless the Agency assigns one person to schedule ALL meetings) Define review criteria Conduct quarterly audit

Role	***Responsibilities***
	Assist QA team with audit preparation Produce quarterly reports
Quality Analyst 1 Clay Gaddis – Procurement	Review all deliverable definition documents Review all products Conduct quarterly audit
Quality Analyst 2 Jo Ann Williams – Training	Review all deliverable definition documents Review all products Develop training material and conduct training sessions Conduct quarterly audit
Quality Analyst 3 Cynthia Taylor – Document Manager	Review all deliverable definition documents Review all products Distribute and track all documents for review Conduct quarterly audit

QUALITY PLAN APPROVALS

Quality Plan Developer – Renee LaRosa _____ Date _____

QA Analyst – Clay Gaddis _____ Date _____

QA Analyst – Jo Ann Williams _____ Date _____

QA Analyst – Cynthia Taylor _____ Date _____

Project Manager – Paul Brannan _____ Date _____

QA Plan (APPENDIX A) - MEETING REVIEW FORM

Meeting Name:	Meeting Date:	
QA Team Member:	Meeting Location:	
Meeting Facilitator:		
1. Did the meeting start on time?	Yes	No
2. Was an agenda published one day prior to the meeting?	Yes	No
3. Did the facilitator call roll?	Yes	No
4. Did the facilitator move unscheduled items to a parking lot?	Yes	No
5. Did the facilitator follow the agenda?	Yes	No
6. Did the facilitator complete the agenda?	Yes	No
7. Did the facilitator identify action items?	Yes	No
8. Did the facilitator review the action items & due date at the end of the meeting?	Yes	No
9. Did the facilitator schedule follow-up on parking lot items?	Yes	No
10. Was the meeting productive?	Yes	No
11. Were meeting notes distributed to attendees within 2 days following the meeting?	Yes	No
Comments or Recommendations:		
QA Action Items:		

QA Plan (APPENDIX B) – AUDIT REPORT

Auditor:	Report Date:
Audit for: *(identify specific product reviewed)*	Project Reference Document(s): *(Project documents reviewed to identify process)*
Audit Date:	Audit Process: (*identify the steps in the audit – meetings, reviews, interviews, etc*)
Documented Process: *(Complete this area before the audit. This will be used to outline the process defined in the project documents – strike through any steps not executed during the audit*)	
Findings: *(Document the findings – steps taken that are not in project document, problems, etc.)*	
Recommendations: *(document any recommendations to the Project Manager)*	
Results of Audit: __ Pass __ Process correction required __ Project Documentation correction required __ Did not follow Process with below quality results	Process Followed: Yes No Results Satisfactory: Yes No
Audit Results Explanation: *(Justification for the results of audit selected)*	

QA Plan (APPENDIX C) – AGENCY REVIEW COMMENTS

Alabama Medicaid Agency						
Review Comment Responses and Resolution						
Author:						
Reviewer:						
Version					V 0.01	
Due Date:					**12/31/2099**	
Comment Number	**Reviewer**	**Page #**	**Section #**	**Text**	**Comment**	**Response**

Note: ARC logs will not contain blank lines or merged cells. This will enable the use of filters. The format of the document shall not be altered except by the Document Manager

QA ISSUE TRACKING SPREADSHEET

2011 MMIS Procurement
QA Issue Tracking Spreadsheet

QA Issue number	Qa Team Member	Date Opened	Issue Source	Issue Description	Resolution	Issue date closed
0	*(name of QA team Member)*	*(date issue is opened)*	*(name of document or meeting)*	*(description of the issue)*	*(description of the resolution)*	*(date issue is closed)*
1						
2						
3						
4						
5						

QUARTERLY QA REPORT DELIVERABLE DEFINITION

QA Activities for the Quarter

QA Summary

This section will be used to give a project overview in relation to our quality goals.

Project Monitoring

Project Plans Reviewed

This section will identify all project plans reviewed and any findings or actions taken.

Project Schedule Reviewed

This section will give a summary of the QA review of the project plan.

Project Documents & Versioning

Project Documents Reviewed

This section will identify all project documents reviewed and any findings or actions taken.

Document Versioning

This section will identify any document versioning issues

Monitor Meetings

This section will identify meetings attended. It will also note any issues identified during the meeting.

Project Traceability

This section will identify any document traceability issues

Quality Issues

This section will contain all the open quality issues.

7.16 Appendix P - Disclosure Statement

State of Alabama
Disclosure Statement
(Required by Act 2001-955)

ENTITY COMPLETING FORM

ADDRESS

CITY, STATE, ZIP TELEPHONE NUMBER ( )

STATE AGENCY/DEPARTMENT THAT WILL RECEIVE GOODS, SERVICES, OR IS RESPONSIBLE FOR GRANT AWARD

ADDRESS

CITY, STATE, ZIP TELEPHONE NUMBER ( )

This form is provided with:

☐ Contract ☐ Proposal ☐ Request for Proposal ☐ Invitation to Bid ☐ Grant Proposal

Have you or any of your partners, divisions, or any related business units previously performed work or provided goods to any State Agency/Department in the current or last fiscal year?

☐ Yes ☐ No

If yes, identify below the State Agency/Department that received the goods or services, the type(s) of goods or services previously provided, and the amount received for the provision of such goods or services.

STATE AGENCY/DEPARTMENT	TYPE OF GOODS/SERVICES	AMOUNT RECEIVED

Have you or any of your partners, divisions, or any related business units previously applied and received any grants from any State Agency/Department in the current or last fiscal year?

☐ Yes ☐ No

If yes, identify the State Agency/Department that awarded the grant, the date such grant was awarded, and the amount of the grant.

STATE AGENCY/DEPARTMENT	DATE GRANT AWARDED	AMOUNT OF GRANT

1. List below the name(s) and address(es) of all public officials/public employees with whom you, members of your immediate family, or any of your employees have a family relationship and who may directly personally benefit financially from the proposed transaction. Identify the State Department/Agency for which the public officials/public employees work. (Attach additional sheets if necessary.)

NAME OF PUBLIC OFFICIAL/EMPLOYEE	ADDRESS	STATE DEPARTMENT/AGENCY

OVER

2. List below the name(s) and address(es) of all family members of public officials/public employees with whom you, members of your immediate family, or any of your employees have a family relationship and who may directly personally benefit financially from the proposed transaction. Identify the public officials/public employees and State Department/Agency for which the public officials/public employees work. (Attach additional sheets if necessary.)

NAME OF FAMILY MEMBER	ADDRESS	NAME OF PUBLIC OFFICIAL/ PUBLIC EMPLOYEE	STATE DEPARTMENT/ AGENCY WHERE EMPLOYED

If you identified individuals in items one and/or two above, describe in detail below the direct financial benefit to be gained by the public officials, public employees, and/or their family members as the result of the contract, proposal, request for proposal, invitation to bid, or grant proposal. (Attach additional sheets if necessary.)

Describe in detail below any indirect financial benefits to be gained by any public official, public employee, and/or family members of the public official or public employee as the result of the contract, proposal, request for proposal, invitation to bid, or grant proposal. (Attach additional sheets if necessary.)

List below the name(s) and address(es) of all paid consultants and/or lobbyists utilized to obtain the contract, proposal, request for proposal, invitation to bid, or grant proposal:

NAME OF PAID CONSULTANT/LOBBYIST	ADDRESS

By signing below, I certify under oath and penalty of perjury that all statements on or attached to this form are true and correct to the best of my knowledge. I further understand that a civil penalty of ten percent (10%) of the amount of the transaction, not to exceed $10,000.00, is applied for knowingly providing incorrect or misleading information.

Signature Date

Notary's Signature Date Date Notary Expires

Act 2001-955 requires the disclosure statement to be completed and filed with all proposals, bids, contracts, or grant proposals to the State of Alabama in excess of $5,000.

7.17 Appendix Q - AMMIS Enhancements

The Vendor shall be required to manage the following requirements in accordance with *Section 2.04 Enhancement Implementation Phase (EIP) - Statement of Work.*

Req. #	Requirement
	Miscellaneous Enhancements
3.01.165	The Vendor shall recommend cost savings proposals to the Agency as described in Appendix M of this ITB.
3.02.121	The Vendor shall provide staffing levels for the PAC and EMC to achieve an average of two and a half minute or less hold time with an 8.5% or less abandonment rate after fifteen (15) seconds. Therefore, an answer rate of 91.5% or greater has been targeted.
3.02.122	The Vendor shall use USPS approved software to convert the Provider mail to address in the PMF to conform with standardized USPS regulations. This includes adding Zip + 4.
3.01.115	The Vendor shall perform cycle monitoring, internal team meetings, software configuration management, release management and all quarterly and annual reoccurring file updates (including SURS control files or equivalent functionality) as system maintenance tasks. These tasks will not be billable or use system modification hours.
3.01.172	The Vendor shall comply with all federal HIPAA Privacy and Security Rules as if the Vendor was a covered entity.
3.01.173	The Vendor shall designate a Privacy Officer and Security Officer. One individual may serve in the capacity of both Privacy and Security Officer. The Vendor shall obtain Agency approval of their Privacy and Security Officer designee(s).
3.01.174	The Vendor shall perform a bi-annual technical and nontechnical security evaluation based on the standards outlined in 45 CFR Part 164, Subpart C, Security Standards for the Protection of Electronic Protected Health Information, on or before December 31st. The evaluation shall be considered system maintenance.
3.01.175	The Vendor shall correct all deficiencies identified by the security evaluation to bring the Vendor into compliance with the HIPAA Security Rule. The correction of the deficiencies shall be considered system maintenance.
3.01.176	The Vendor shall present a plan of action for correcting all deficiencies found during the security evaluation within thirty 30 (thirty) days of completing the evaluation. The plan of action shall include processes and estimated completion dates. The plan must be approved by the Agency before it is implemented. The production of the plan shall be considered system maintenance.
3.01.177	The Vendor shall within 30 (thirty) days of the date of completing the HIPAA security evaluation provide the Agency a copy of the security evaluation report. The Agency reserves the right to share the contents of the security evaluation report with other entities as deemed necessary in the furtherance of the objectives of the Agency.
3.01.178	The Vendor shall notify the Agency no later than one (1) business day following the discovery of a breach of Protected Health Information (PHI).
3.01.179	The Vendor shall provide the following information and obtain Agency approval prior to reporting a breach as required by 45 CFR Part 164, Subpart D: - The number of recipient records involved in the breach. - A brief description of what happened, including the date of the breach and the date of the discovery of the breach if known. - A description of the types of unsecure protected health information that were involved in the breach (such as whether full name, social security number, date of birth, home address, account number, diagnosis, disability code, or other type information were involved).

Req. #	Requirement
	- Any steps the individuals should take to protect themselves from potential harm resulting from the breach. - A brief description of what the Vendor is doing to investigate the breach, to mitigate harm to individuals and to protect against any further breaches. - Contact procedures for individuals to ask questions or learn additional information, which shall include the Vendor's toll-free number, email address, Web site, or postal address. - A proposed media release developed by the Vendor.
3.01.180	After Agency approval, the Vendor shall provide the necessary notices to the recipient, prominent media outlet, or the Secretary of Health and Human Services (HHS) to report Vendor breaches as required by 45 CFR Part 164, Subpart D.
3.01.181	The Vendor shall pay all fines or penalties imposed by HHS under 45 CFR Part 160 HIPAA Administrative Simplification: Enforcement rule for breaches made by any employee, officer, or agent of the Vendor.
3.01.182	The Vendor shall pay all costs associated with notifying the Agency, recipients, media outlets, and HHS for breaches made by any employee, officer, or agent of the Vendor.
	Document Repository Enhancement - these changes will provide an audit trail of modifications to project documents, map the 2004 ITB requirements to the 2011 ITB requirements and continue to maintain the requirements throughout the contract to reflect the current state of the AMMIS.
3.01.143	The repository used for the project documents and documentation must have an audit trail and versioning for all documents. This would capture date changed and changed by. It shall also retain a minimum of ten (10) previous versions.
3.01.166	The Vendor shall update all iTRACE documentation to reflect the new ITB Requirements and numbering.
3.01.167	The Vendor shall update all other documentation which currently references prior ITB Requirements and numbering with the new ITB Requirements and numbering.
3.01.168	The Vendor shall identify all change orders implemented which have resulted in additional or modified system functionality and draft new system requirements to reflect those changes for Agency approval by September 1, 2011.
3.01.169	The Vendor shall, as part of the implementation of all change orders or defects, identify and update the associated requirement(s). If there are no requirements for this change, the Vendor shall write the new requirement(s). The new or updated requirement(s) shall be submitted to the Agency for approval prior to implementation.
3.01.170	The Vendor shall as part of the implementation of any change orders or defects, update all other documentation with the new or updated requirement(s) and requirement(s) numbering. The modified documents must be presented to the Agency for approval prior to implementation.
	Security Enhancement - This piece of hardware will allow the Vendor to destroy the data from all media types. This is required for security regulation compliance.
3.01.140	The Vendor shall have an in-house degausser for all media types received and/or maintained by the Vendor.
	HIPAA 5010 electronic transaction Enhancement - The Code of Federal Regulations (CFR) has been revised to require the use of the following transaction and code sets effective 01/01/2012: ASC X12N 005010 with applicable Errata National Council for Prescription Drug Programs (NCPDP) D.0/Batch 1.2 NCPDP Batch 3.0 for Medicaid Subrogation of Pharmacy Claims (New Transaction)

Req. #	Requirement
3.01.013	The system shall be modified to process HIPAA EDI transactions in the ASC X12 4010 format and the ASC X12 5010 format concurrently. This shall allow the Agency to discontinue the use of ASC X12 4010 transactions with an automated error message being returned to the sender. The fiscal agent shall identify all vendors using 4010 transactions and generate notices announcing discontinuation of ASC X12 4010 support in advance of the discontinuation. The date for production of said notices shall be determined by the Agency.
3.01.014	The system shall be modified to process HIPAA EDI NCPDP 5.1 (interactive) and NCPDP 1.1 (batch) concurrently with HIPAA EDI NCPDP D.0 (interactive) and NCPDP 1.2 (batch) transactions concurrently. This shall allow the Agency to discontinue the use of NCPDP 5.1 and NCPDP 1.1 transactions with an automated error message being returned to the sender. The fiscal agent shall identify all vendors using NCPDP 5.1 and NCPDP 1.1 transactions and generate notices announcing discontinuation of NCPDP 5.1 and NCPDP 1.1 support in advance of the discontinuation. The date for production of said notices shall be determined by the Agency.
3.01.015	The MMIS shall be fully capable of processing, displaying, searching and reporting all data fields from all NCPDP and ASC X12 5010 transactions in all panels, reports, processes, etc. All fields, reports or processes, etc. currently using ICD-9 codes shall be capable of using ICD-10 codes without modification.
3.01.150	The Vendor shall modify the MMIS (including TPL) to concurrently transmit and receive Claims/Encounter transactions in the HIPAA X12N 4010 X098A1 (837 P), X12N 4010 X097A1 (837 D), X12N 4010 X096A1 (837 I) and the HIPAA2 X12N 5010 X222 E1 (837 P), X12N 5010 X224A1 E1 (837 D), X12N 5010 X223A1, E1 (837 I) formats.
3.01.151	The Vendor shall modify the MMIS (including TPL) to concurrently transmit and receive remittance advice in the HIPAA X12N 4010 X091A1 (835) and the HIPAA2 X12N 5010 X221E1 (835) formats.
3.01.152	The Vendor shall modify the MMIS (including TPL) to concurrently transmit and receive eligibility inquiries and responses in the HIPAA X12N 4010 X092A1 (270/271) and the HIPAA2 X12N 5010 X279E1 (270/271) formats.
3.01.153	The Vendor shall modify the MMIS (including TPL) to concurrently transmit and receive benefit enrollment and maintenance transactions in the HIPAA X12N 4010 X095A1 (834) and the HIPAA2 X12N 5010 X220E1 (834) formats.
3.01.154	The Vendor shall modify the MMIS (including TPL) to concurrently transmit and receive premium payment transactions in the HIPAA X12N 4010 X061A1 (820) and the HIPAA2 X12N 5010 X218E1 (820) formats.
3.01.155	The Vendor shall modify the MMIS (including TPL) to concurrently transmit and receive Authorization and Referral Request and Response (Non-Pharmacy) transactions in the HIPAA X12N 4010 X094A1 (278) and the HIPAA2 X12N 5010 X217E1, E2 (278) formats.
3.01.156	The Vendor shall modify the MMIS (including TPL) to concurrently transmit and receive Claim Status Inquiry and Response transactions in the HIPAA X12N 4010 X093A1 (276/277) and the HIPAA2 X12N 5010 X212E1, E2 (276/277) formats.
3.01.157	The Vendor shall modify the MMIS (including TPL) to concurrently transmit and receive Pharmacy Claim /Encounter transactions in the HIPAA NCPDP 5.1 (interactive), NCPDP 1.1 (batch) and NCPDP D.0 (interactive), NCPDP 1.2 (batch) formats.
3.01.158	The Vendor shall modify the MMIS (including TPL) to transmit and receive Pharmacy Supplies and Professional Services Claim/Encounter transactions in the HIPAA X12N 5010 X222E1 (837P) or NCPDP D.0 (interactive) and NCPDP 1.2 (batch) formats.

Req. #	Requirement
3.01.159	The Vendor shall modify the MMIS (including TPL) to concurrently transmit and receive Pharmacy Eligibility Inquiry and Response transactions in the HIPAA NCPDP 5.1 (interactive), NCPDP 1.1 (batch) and the HIPAA2 NCPDP D.0 (interactive), NCPDP 1.2 (batch) formats.
3.01.160	The Vendor shall modify the MMIS (including TPL) to concurrently transmit and receive Pharmacy Authorization and Referral Request and Response (Retail Pharmacy) transactions in the HIPAA NCPDP 5.1 (interactive), NCPDP 1.1 (batch) and the HIPAA2 NCPDP D.0 (interactive), NCPDP 1.2 (batch).
	ICD-10 Impact Assessment - The transition from ICD-9 to ICD-10 has an effective date of 10/1/2013. This transition will not be included in this ITB, but an impact assessment will be required. The impact assessment will identify the changes required to the AMMIS to receive the maximum benefits from this transition.
3.01.163	The Vendor shall provide an analysis to the highest specificity of the impacts that result with the transition from the ICD 9 to ICD 10. The analysis shall include but not be limited to: - new code to similar code/deleted code, - age, - gender - BPA (Benefit Plan Administration) - recipient plan - edits/audits - diagnosis groups and ICD Surgical procedure groups - crosswalks of all system and adhoc reports that utilize ICD codes - all other impacted portions of the AMMIS All field lengths for ICD-10 shall match system wide. The Vendor shall provide an impact statement to the Agency during the Analysis phase of the Design, Development and Implement phase.
3.04.016	The Vendor shall provide an Annual analysis to the highest specificity of the impacts that result from the ICD 9/10 Diagnosis and Surgical Procedure code updates. The analysis shall include but not be limited to: - new code to similar code/deleted code - age, - gender - BPA (Benefit Plan Administration) - recipient plan - edits/audits - diagnosis groups and ICD Surgical procedure groups The Vendor shall provide the analysis to the Agency by the first business day of September.
3.04.015	The Vendor shall, without notification from the Agency, retrieve from the CMS website the annual ICD-9/10, Diagnosis and Surgical procedure codes. The information is available in August and will be applied by Sept 15th with an effective date of Oct 1st to the highest level of specificity.
	Provider Enrollment/Re-enrollment Enhancement - these changes will require the Vendor to re-enroll all providers every five (5) years and to re-enroll targeted providers every year. The Vendor will be required to closely monitor the Durable Medical Equipment (DME) providers and home health providers with onsite verification performed for each enrolling/re-enrolling DME provider.

Req. #	Requirement
3.02.118	Prior to enrollment the vendor shall verify through on-site visits that durable medical equipment (DME) provider applicants have fully functional locations and meet the requirements specified in the Alabama Medicaid Administrative Code Chapter 13 and the Provider Billing Manual.
3.02.119	The Vendor shall establish provider end date for home health and durable medical equipment (DME) enrollees as the date their current business license expires. The Vendor shall conduct re-enrollment prior to license expiration and in accordance with initial enrollment process.
3.02.120	The Vendor shall conduct re-enrollment of all providers, except home health and DME, every five (5) years. The Provider re-enrollment shall include Patient 1st re-enrollment. The initial re-enrollment shall occur during the first year of operations.
3.02.054	The Vendor shall maintain provider enrollment personnel with a minimum of ten (10) FTEs - Enrollment Specialists, one (1) FTE - Quality Assurance, and one (1) FTE Enrollment Supervisor.
3.02.071	The Vendor shall store all provider enrollment call center, provider representative call center, and provider assistance call center recordings in a secured area accessible by the Agency. All calls from these Call Centers shall be retained for a minimum of twelve (12) months. The Vendor shall work with the Agency to define search criteria to easily locate specific calls. The search criteria shall include, but not be limited to call date, time, phone number the call originated from, Provider name, Provider ID or call identifier, and the Call Center worker. If requested, the Vendor shall provide the Agency with a copy of the voice recording within one (1) hour of request.
3.02.114	The Vendor shall maintain a 99.8% accuracy rate for processing provider applications and entering information into the system. 99.8% accuracy applies to the following data fields: - All Provider Names - Provider ID (NPI) - Provider Addresses (All to include city, county, state, 9-digit zip code, service location, pay to, mail to and home office) - Telephone/Fax Numbers - License Number - SSN - CLIA Number - Contract effective and end dates - Primary Contact name If the accuracy rate falls below 99.8%. The Vendor shall develop and submit to the Agency for approval a performance improvement plan within five (5) days of notification of deficiency. The plan must be implemented within five (5) days of approval by the Agency. If the plan does not correct the deficiency within three (3) months a revised plan must be submitted and approved.
3.02.134	The Vendor shall provide on a monthly basis operational reports from the provider enrollment staff, provider representative staff, and provider assistance center about the types of inquiries received during the month, by hour segment and day. The monthly reports shall cover the previous month's activity and be provided no later than the 5th day of the month. The Vendor shall work with the Agency to define the types of inquiries to be tracked.
	Provider Web Application - these changes will add functionality to the Vendor's Provider web. The changes will allow providers to submit enrollment and update information via the Web with real-time validation of the data entered.
3.02.123	The Vendor shall develop a secured web application that allows Providers to submit all required information on the enrollment/re-enrollment applications and make Agency defined changes to the Provider's information.

Req. #	Requirement
3.02.124	The Vendor's provider web application shall allow the Providers to update selected information. The Vendor shall work with the Agency to identify the information Providers are allowed to update. The information Providers are allowed to update through the web application will not require a provider signature page.
3.02.125	The Vendor shall define a process to report statistics associated with the provider web portal. The process and statistics reported must be approved by the Agency. The statistics will include but not be limited to the performance measures, provider usage and application errors associated with the provider web application.
3.02.126	The Vendor's provider web application will edit the provider application entry and update fields for presence, validity and formatting when possible. The field validation will use data that is maintained in the AMMIS and return applicable error messages on-line real-time. Enrollment information that is not maintained in the AMMIS shall be validated and a response returned to the Provider within five (5) days of entry. Update information that is determined to be incorrect or in error shall be returned to the Provider within two (2) days of entry.
3.02.127	The Vendor's provider web application shall validate the Provider mailing and physical (service location) addresses using USPS approved software. The zip + 4 will be validated if entered or added at time of entry if not supplied by the Provider.
3.02.128	The Vendor's provider web application shall use the Managed Care defined process to identify or validate the Provider county based on the service location.
3.02.129	The Vendor shall capture all information entered in the Provider web portal. The information shall be stored in the Provider Master File or another location approved by the Agency.
3.02.130	The Vendor's provider web application shall provide the capability to print the entire application form with the information entered by the Provider. The Provider will be informed that they must print and sign specified signature pages. These signature pages and any other documents requested shall be mailed to the address indicated and received by the Vendor within ten (10) days of entry.
3.02.131	The Vendor's provider web application shall create a facsimile in the electronic document database for every electronically submitted enrollment application or update. The Vendor shall assign tracking numbers to all facsimiles. The Vendor shall store the documents in a method that allows for search by Provider name and Provider number, if assigned.
3.02.132	The Vendor shall develop a plan to educate the providers on the new web based enrollment and update application. The Provider education plan shall be submitted to the Agency for approval. The Vendor shall begin implementing the Agency approved Provider education plan within an Agency approved time frame.
3.02.133	The Vendor's Provider enrollment staff shall support all Provider inquiries on the Provider enrollment and update web application.
	Recipient Claim History Enhancement - These changes will provide a report from the AMMIS that contains a history of a recipients claims. This report will be used by the Agency to verify a recipient's claims and correct any errors.
3.03.047	The Vendor shall maintain a process to generate recipient claim history requests and show all claims, adjustments, and financial transactions that have occurred for the selection parameters requested. The process shall access all claims history and all claim types. The reports shall be produced within one (1) day of the request and shall be printed on single-sided paper and delivered to the Agency in the standard mail run. Due to the one day turn-around requirement, the reports shall be produced from the MMIS (DSS is not updated nightly). The reports shall be produced by recipient (including merged recipient ID numbers) not claim type. The report shall include a description of procedure, drug, diagnosis, error codes and provider name.

Req. #	Requirement
	Recipient Web Portal Enhancement - The Vendor will be required to expand the current functionality of the recipient web portal. These enhancements will allow recipients to update selected information.
3.03.116	The Vendor shall provide an Alabama Medicaid Interactive Web Site which requires an entry of the Recipient ID and their Date of Birth to access a Recipient's data.
3.03.117	The Vendor shall provide an Alabama Medicaid Interactive Web Site which allows Recipients the option to report changes via the web. The recipient web application shall allow the recipient to print an Agency approved change form and provide a Vendor e-mail, a Vendor fax number and a Vendor mailing address for form submission. The Vendor shall update the AMAES application within one (1) day of receipt of the change from the web, fax, e-mail or mail. This applies to updates referenced in Requirements 3.03.077, 3.03.078, 3.03.119, 3.03.122, & 3.03.123.
3.03.118	The Alabama Medicaid Interactive Web Site shall provide in response to the Recipient entering their Recipient ID and Date of Birth the following information: - Recipient Name - Recipient Status (Active or Inactive) - Patient 1st Doctor Name, Address and Telephone Number. The Recipient status if active shall identify the "through date".
3.03.119	The Alabama Medicaid Interactive Web Site shall allow Recipients to view available Providers based on provider enrollment criteria such as but not limited to number of current patients or proximity to the Recipient's location. The Recipient shall be able to select a Patient 1st Provider from the list of available Providers. At the time of the selection, the web application shall notify the recipient of the effective date for the selected Provider.
3.03.120	The Alabama Medicaid Interactive Web Site shall allow the Recipient to request a replacement card. The Vendor shall issue replacement cards in accordance with current Agency policy. The web application shall allow recipients to print the Agency approved Medical Services Eligibility Verification (MSEV) form.
3.03.121	The Alabama Medicaid Interactive Web Site shall provide the Recipient with benefit limits used and benefits available for those services for which they are eligible. The benefit used and available shall identify the "as of date".
3.03.122	The Alabama Medicaid Interactive Web Site shall allow the recipient to submit an Agency approved change request on-line real-time. The change request shall allow the recipient to change the following information: - Address - Home Phone with Area Code - Cell Phone - E-mail Address - Marital Status - Sponsor Address - Family Changes, - Income Changes, - Expense Changes, - Insurance Changes, - Report of Death, - Ability to close a Medicaid Account or withdraw an Application, and - A free text area to enter other change information with an effective date for the change. The Vendor shall receive the information entered on the web and make the changes in the AMAES application within one (1) day of receipt.

Req. #	Requirement
3.03.077	The Vendor shall update eligibility file change requests received via phone and/or web application to change name, address, sex code, phone number, county code, marital status, and/or race for MLIF, SOBRA, and Plan First certified cases.
3.03.078	The Vendor shall update the eligibility file change requests received via phone and/or web application to change address, phone number, and marital status of the beneficiary and update sponsor's address and phone number for District Office (Elderly & Disabled) certified cases. For marital status changes, the spouse's name, address, SSN & DOB must be verified.
3.03.070	The Vendor shall provide application status (pending=P; awarded =A; denied=D; and terminated =T) to applicants. For pending cases (if application was received less than forty-five (45) days from the date of the call, the Call center Representative shall check the file to see if the application shows up in the system as pending. If so, respond that the case is pending. If it does not show up in the system, respond that Medicaid has forty-five (45) days to process a case and the application may not have been entered into the system yet. Advise them to check back in 7-10 days. If the application was received more than forty-five (45) days from the date of the call, then refer to the assigned caseworker using the caseworker file to look up the workers name and phone number. For denied cases then refer to the assigned caseworker using the caseworker file to look up the worker's name and phone number. For terminated cases instruct the individual to complete another application [mail the appropriate applications to the individual and/or direct them to the web application]).
	Drug Maintenance Enhancement - These changes will require the Vendor to assume the support and maintenance of the drug data warehouse. The Vendor will contract directly with a drug data warehouse vendor to provide periodic updates. The Vendor will be responsible for all maintenance and reporting associated with the drug data warehouse. The Vendor will enhance the Provider web portal to include a drug look-up function.
3.04.073	The Vendor shall maintain license agreement on behalf of the Agency with the data warehouse. The license agreement shall accommodate the average monthly claim count of 200,000 to 2 million. At the time of writing this ITB, the Agency averages 600,000 pharmacy claims per month (FY08).
3.04.076	The Vendor shall provide a drug look up system for providers to sign into and look up prices and coverage (e.g., PA status, PDL status) information for specific NDC's. The Vendor shall obtain Pharmacy Service staff approval of the drug lookup system.
3.04.083	The Vendor shall maintain any drug information provided by the data warehouse that is currently not used in the Reference subsystem.
3.04.084	The Vendor shall provide a staff member as the primary contact for the Agency concerning the drug data warehouse. The Vendor shall provide a backup point of contact should the primary liaison be unavailable. The Vendor's point of contact for the drug data warehouse responsibilities shall include, but are not limited to: • Assist the Agency with any data warehouse related questions. • Contact the data warehouse to verify any information related to the drug file. • Return messages/correspondence from the Agency within one business day. • Meet with Agency staff upon request.
3.04.085	The Vendor shall ensure that the drug data warehouse identifies a primary and secondary point of contact. The Agency must have the ability to contact the data warehouse directly without contacting the Vendor.

Req. #	Requirement
	E-Prescribing Enhancement - The Vendor will build the e-prescribing functionality within the AMMIS. As a result of these changes, participating physicians will have a comprehensive view of recipient eligibility and medication histories across all participating payers.
3.04.119	The Vendor shall make available to SureScripts-RxHub the following information which shall be available to Alabama e-prescribers with SureScripts-RxHub access: • Eligibility information• Medication histories • Benefit plan details, such as - Preferred Drug List - Prior Authorizations - Co-payments - Dosages - Drug Utilization Reviews - Quantity Limitations.
3.04.120	The Vendor shall ensure transactions to Alabama's MMIS are received from SureScripts-RxHub, so that recipient eligibility and medication history data can be exchanged.
3.04.121	The Vendor shall configure the AMMIS to respond to SureScripts-RxHub e-prescribing requests.
3.04.122	The Vendor shall provide SureScripts-RxHub with the Agency's drug PDL and benefit information by providing data files that break down the Agency's drug benefit and policy rules into the following categories: • PDL Status • Drug Classification • Coverage Text Message • Product Coverage Exclusion • Prior Authorization • Quantity Limits • Age Limits • Gender Limits • Resource Link • Benefit Co-pay • Cross-Reference Detail Updates to any of these categories shall be sent to SureScripts-RxHub within twenty-four (24) hours of notification by the Agency.
3.04.123	The Vendor shall provide SureScripts-RxHub with the preferred status of the Agency drugs. The Agency currently supports one PDL listing for all benefit groups.
3.04.124	The Vendor shall create a new AMMIS on-line panel to support drug classifications. This panel shall allow a user to enter a drug, GFC (Generic Formula Code), or list where an alternatives class ID or subclass ID can be listed. These rules shall be based on a recipient's eligibility program to allow flexibility that drug classifications can be different among programs. The Vendor shall extract all active drug classification rules and send them to SureScripts-RxHub along with the drug classification ID, which associates the drug data with a recipient's program.
3.04.125	The Vendor shall create a new AMMIS on-line panel to support specific NDC related text messages. This panel shall allow a user to enter a National Drug Code (NDC), Generic Formula Code (GFC), or list along with a two hundred (200) character text message. The Vendor shall extract all active text message rules and send them to SureScripts-RxHub. This transaction shall allow specific messages to be conveyed about particular drugs.
3.04.126	The Vendor shall transmit a product coverage exclusion transaction which allows exclusion criteria related to an NDC to be returned to SureScripts-RxHub. Products for nonparticipating manufacturers shall be returned in this transaction, specific to the eligibility program that is applicable.
3.04.127	The Vendor shall return current, active, payable NDCs requiring prior authorization (PA). This shall provide SureScripts-RxHub with all the current drugs where a PA is

Req. #	Requirement
	required, based on the PA indicator on the Agency's drug file.
3.04.128	The Vendor shall allow NDCs to be returned in the extract file when the NDC has a quantity limit. All records sent to SureScripts-RxHub shall be NDC-specific, and the data provided shall include the drug, maximum quantity, and time period associated with the quantity.
3.04.129	The Vendor shall return each current, active, payable NDC with an age restriction. This shall provide SureScripts-RxHub with all the current drugs where age restrictions are applicable, based on the age criteria on the Agency's drug file. This transaction can specifically address recipient fraud if the same names are used between generations and only the children qualify for the program.
3.04.130	The Vendor shall return each current, active, payable NDC with a gender restriction. This shall provide SureScripts-RxHub with all the current drugs where gender restrictions are applicable, based on the gender criteria on the Agency's drug file.
3.04.131	The Vendor shall provide the capability for a Web link to be returned to SureScripts-RxHub in the extract file. Web links are useful for providing a pathway to prescribers for forms or information that may be needed during the prescription-generating processes. For example, links to prior authorization forms are provided when the forms are required to prescribe certain prescriptions. There are two types of resource link transactions. There is a resource link summary transaction and a resource link drug-specific transaction. For each transaction, a resource link "type" shall indicate the type of information being conveyed. There are ten types of resource links allowed: Age Limit, Product Coverage Exclusion, Gender Limits, Medical Necessity, Prior Authorization, Quantity Limits, Step Therapy, General Information, Co-pay, and Formulary. The resource link drug-specific transaction is associated with a drug where the summary transaction is not. Updates to resource links shall be part of system maintenance.
3.04.132	The Vendor shall allow specific Agency co-pay rules to be returned. These rules shall be based on a recipient's eligibility program to allow reporting flexibility for the different programs. Although Agency policy currently supports one co-payment based on the cost of the medication, this functionality shall provide a means of communicating to the practitioner whether a tiered co-payment would be applied if Agency policy changes, based on the flexibility allowed with the passage of the Deficit Reduction Act.
3.04.133	The Vendor shall create a new AMMIS on-line cross-reference detail panel to support the recipient's formulary and benefit information. This panel shall allow a user to enter a health plan name associated with an aid category list, alternative ID, coverage ID, co-pay list ID, and classification ID. All this information shall be used to support the interactive eligibility request that is sent through SureScripts-RxHub. This panel ties a recipient's benefit information together and allows a prescriber to access the recipient's benefit information.
3.04.134	The Vendor shall provide SureScripts-RxHub the Agency's recipient information from the AMMIS. The Vendor shall send a one-time master file, followed by nightly updates based on changes to recipient data. The information shall be sent in the SureScripts-RxHub file layout along with all the data elements being requested. SureScripts-RxHub shall use these files to establish uniqueness for recipients among the different third-party vendors.

Req. #	Requirement
3.04.135	The Vendor shall provide a recipient's prescription medication history to SureScripts-RxHub from the AMMIS via the current NCPDP Script medication history transaction format. This transaction allows the flexibility for up to fifty (50) paid history prescriptions to be returned to a valid Agency provider/prescriber. The number of claims returned in the response shall be based on the number of prescriptions the recipient has in history, the age of the claims, and ensuring adequate response times. Paid prescription data within a specified time period shall be gathered from the AMMIS and returned in this transaction, based on SureScripts-RxHub's data requirements. The Vendor shall optimize response times so that response time does not limit the maximum number of scripts that are returned.
3.04.136	The Vendor shall modify the 270 and 271 eligibility request and response transactions to provide additional information to SureScripts-RxHub specific to a recipient's benefit and PDL information. Additional processing rules, within the HIPAA guidelines, are requested to support SureScripts-RxHub's processing. These processing rules shall be incorporated into this transaction to aid SureScripts-RxHub. The PDL and benefit load information shall be retrieved from the new AMMIS on-line panel under this cross-reference detail transaction. By using the benefit IDs returned in this transaction, a prescriber can access a recipient's PDL information through SureScripts-RxHub.
3.04.137	The Vendor shall report transactions for requested recipient eligibility and medication history data on a monthly basis. The Vendor shall include reporting data for point-of-care (POC) technology vendor participation, transaction performance, and trending analysis for e-prescribing adoption and use. There are two main data sources for the transactions statistics—one from SureScripts-RxHub and the other from the AMMIS system. The information from both sources shall be combined to present reports that summarize all the available data. Reports shall be provided to the Agency the 5th day of the month.
3.04.138	The Vendor shall report prescription-related counts and related information as data becomes available
3.04.139	The Vendor shall make available through the existing WEB Portal the ability to perform full electronic prescribing capabilities. Interactive, real-time patient data should enable full clinical decision support and electronic transmission to any pharmacy in the SureScripts network. The ePrescribing module shall be fully certified with the SureScripts Health Information Network and enrolled Medicaid providers should have the ability to service all of their current and future patients. The provider portal should offer a no-cost option, assuming the provider has access to the Internet at their office.
	CCI (Correct Coding Initiatives) Enhancement - This enhancement will automate the process of applying the CMS quarterly CCI updates to the AMMIS.
3.01.088	Contract required personnel for the Operations Phase of the contract include: EIS/DSS Technical support, Customer Relations staff, EMC Coordinator, Modification Teams, HCPCS Coordinator, SURS Analyst, TCM (Targeted Case Management) Prior Authorization Coordinator, Medical Policy Specialist, Quality Assurance Manager, Provider Quality Assurance Evaluator, Systems/Technical Support and a total of two (2) Medical Policy Analysts of which one (1) shall be a Registered Nurse in the State of Alabama and a Certified Professional Coder (CPC) through the American Academy of Professional Coders and the other shall be at a minimum a Certified Professional Coder (CPC) through the American Academy of Professional Coders.
3.04.143	The Vendor shall implement Correct Coding Initiatives (CCI) Edits for physician and outpatient hospital claims in accordance with CMS guidelines. The Vendor shall meet with the Agency prior to the initial implementation of the CCI Edits to identify those applicable to the Alabama Medicaid Agency.

Req. #	Requirement
3.04.144	The Vendor shall subscribe to CMS quarterly updates for the CCI Edits. CMS sends notifications quarterly of the changes to the CCI Edits. The Vendor shall meet with the Agency within five (5) days of the CMS email notification to determine the CCI Edits applicable to the Agency. The Vendor shall implement the Agency approved CCI Edits within ten (10) days of obtaining Agency approval.
3.04.145	The Vendor shall review all CCI edits identified and provide end to end test results to ensure edits are working properly prior to implementation. This shall include regression testing.
3.06.075	The Vendor shall perform all data processing operations to support Claims/Encounter processing requirements, including: - On-line real-time Edit/Audit processing including Correct Coding Initiatives (CCI) Edits; - Suspense resolution; - On-line real-time Claim pricing; and - On-line real-time Adjudication processing.

7.18 Appendix R - MITA Maturity Matrix

The spreadsheet below represents the results of the Agency's MITA State Self Assessment which was completed December 2009.

MITA BUSINESS AREA	ALABAMA BUSINESS AREA	MITA BUSINESS PROCESS	ALABAMA BUSINESS PROCESS	AS IS LEVEL OF BUSINESS CAPABILITY	TO BE LEVEL OF BUSINESS CAPABILITY
Member Management					
Member Management	Member Management	ME Determine Eligibility	ME01 Determine Eligibility	1	1
Member Management	Member Management	ME Enroll Member	ME02 Enroll Member	1	1
Member Management	Member Management	ME Disenroll Member	ME03 Disenroll Member	1	1
Member Management	Member Management	ME Inquire Member Eligibility	ME04 Inquire Member Eligibility	1	1
Member Management	Member Management	ME Manage Application & Member Communication	ME05 Manage Application & Member Communication	1	1
Member Management	Member Management	ME Manage Member Grievance and Appeal	ME06 Manage Member Grievance and Appeal	1	1
Member Management	Member Management	ME Manage Member Information	ME07 Manage Member Information	1	1
Member Management	Member Management	ME Manage Population and Member Outreach	ME08 Manage Population and Member Outreach	1	1
Provider Management					
Provider Management	Provider Management	PM Enroll Provider	PM01 Enroll Provider	1	1
Provider Management	Provider Management	PM Disenroll Provider	PM02 Disenroll Provider	1	1
Provider Management	Provider Management	PM Inquire Provider Information	PM03 Inquire Provider Information	1	1
Provider Management	Provider Management	PM Manage Provider Communication	PM04 Manage Provider Communication	1	1

MITA BUSINESS AREA	ALABAMA BUSINESS AREA	MITA BUSINESS PROCESS	ALABAMA BUSINESS PROCESS	AS IS LEVEL OF BUSINESS CAPABILITY	TO BE LEVEL OF BUSINESS CAPABILITY
Provider Management	Provider Management	PM Manage Provider Grievance & Appeal	PM05 Manage Provider Grievance & Appeal	1	1
Provider Management	Provider Management	PM Manage Provider Information	PM06 Manage Provider Information	1	1
Provider Management	Provider Management	PM Perform Provider Outreach	PM07 Perform Provider Outreach	1	1
Contractor Management					
Contractor Management	Contractor Management	CO Produce Administrative or Health Services RFP	CO01 Produce Administrative or Health Services RFP	1	1
Contractor Management	Contractor Management	CO Award Administrative or Health Services Contract	CO02 Award Administrative or Health Services Contract	1	1
Contractor Management	Contractor Management	CO Manage Administrative or Health Services Contract	CO03 Manage Administrative or Health Services Contract	1	1
Contractor Management	Contractor Management	CO Close-out Administrative or Health Services Contract	CO04 Close-out Administrative or Health Services Contract	1	1
Contractor Management	Contractor Management	CO Manage Contractor Information	CO05 Manage Contractor Information	1	1
Contractor Management	Contractor Management	CO Manage Contractor Communication	CO06 Manage Contractor Communication	1	1
Contractor Management	Contractor Management	CO Perform Contractor Outreach	CO07 Perform Contractor Outreach	1	1
Contractor Management	Contractor Management	CO Support Contractor Grievance and Appeal	CO08 Support Contractor Grievance and Appeal	1	1
Contractor Management	Contractor Management	CO Inquire Contractor Information	CO09 Inquire Contractor Information	1	1
Operations Management					

MITA BUSINESS AREA	ALABAMA BUSINESS AREA	MITA BUSINESS PROCESS	ALABAMA BUSINESS PROCESS	AS IS LEVEL OF BUSINESS CAPABILITY	TO BE LEVEL OF BUSINESS CAPABILITY
Operations Management	Operations Management	OM Authorize Referral	OM01 Authorize Referral	N/A	N/A
Operations Management	Operations Management	OM Authorize Service	OM02 Authorize Service	1	2
Operations Management	Operations Management	OM Authorize Treatment Plan	OM03 Authorize Treatment Plan	N/A	N/A
Operations Management	Operations Management	OM Apply Attachment	OM04 Apply Attachment	1	1
Operations Management	Operations Management	OM Apply Mass Adjustment	OM05 Apply Mass Adjustment	1	1
Operations Management	Operations Management	OM Edit Claim/Encounter	OM06 Adjudicate and Price/Value Claim/Encounter*	1	1
Operations Management	Operations Management	OM Audit Claim/Encounter	OM07 Adjudicate and Price/Value Claim/Encounter*	1	1
Operations Management	Operations Management	OM Price Claim/Value Encounter	OM08 Adjudicate and Price/Value Claim/Encounter*	1	1
Operations Management	Operations Management	OM Prepare Remittance Advice/Encounter Report	OM09 Prepare Remittance Advice/Encounter Report	2	2
Operations Management	Operations Management	OM Prepare Provider EFT/Check	OM10 Prepare Provider EFT/Check	1	1
Operations Management	Operations Management	OM Prepare COB	OM11 Prepare COB	N/A	N/A
Operations Management	Operations Management	OM Prepare EOB	OM12 Prepare REOMB	1	1
Operations Management	Operations Management	OM Prepare Home and Community Based Services Payment	OM13 Prepare Home and Community Based Services Payment	2	2
Operations Management	Operations Management	OM Prepare Premium EFT	OM14 Prepare Premium EFT/Check	1	1
Operations Management	Operations Management	OM Prepare Capitation Premium Payment	OM15 Prepare Capitation Premium Payment	1	2

MITA BUSINESS AREA	ALABAMA BUSINESS AREA	MITA BUSINESS PROCESS	ALABAMA BUSINESS PROCESS	AS IS LEVEL OF BUSINESS CAPABILITY	TO BE LEVEL OF BUSINESS CAPABILITY
Operations Management	Operations Management	OM Prepare Health Insurance Premium Payment	OM16 Prepare Health Insurance Premium Payment	1	1
Operations Management	Operations Management	OM Prepare Medicare Premium Payments	OM17 Prepare Medicare Premium Payments	1	1
Operations Management	Operations Management	OM Inquire Payment Status	OM18 Inquire Payment Status	2	2
Operations Management	Operations Management	OM Manage Payment Information	OM19 Manage Payment Information	1	1
Operations Management	Operations Management	OM Calculate Spend Down Amount	OM20 Calculate Spend Down Amount	N/A	N/A
Operations Management	Operations Management	OM Prepare Member Premium Invoice	OM21 Prepare Member Premium Invoice	N/A	N/A
Operations Management	Operations Management	OM Manage Drug Rebate	OM22 Manage Drug Rebate	2	2
Operations Management	Operations Management	OM Manage Estate Recovery	OM23 Manage Estate Recovery	1	1
Operations Management	Operations Management	OM Manage Recoupment	OM24 Manage Recoupment	2	2
Operations Management	Operations Management	OM Manage Cost Settlement	OM25 Manage Cost Settlement	1	1
Operations Management	Operations Management	OM Manage TPL Recovery	OM26 Manage TPL Recovery	1	1
Program Management					
Program Management	Program Management	PG Designate Approved Service and Drug Formulary	PG01 Designate Approved Service and Drug Formulary	2	2
Program Management	Program Management	PG Develop & Maintain Benefit Package	PG02 Develop & Maintain Benefit Package	2	2
Program Management	Program Management	PG Manage Rate Setting	PG03 Manage Rate Setting	1	1
Program Management	Program Management	PG Develop Agency Goals & Objectives	PG04 Develop Agency Goals & Initiatives	1	1

MITA BUSINESS AREA	ALABAMA BUSINESS AREA	MITA BUSINESS PROCESS	ALABAMA BUSINESS PROCESS	AS IS LEVEL OF BUSINESS CAPABILITY	TO BE LEVEL OF BUSINESS CAPABILITY
Program Management	Program Management	PG Develop and Maintain Program Policy	PG05 Develop & Maintain Program Policy	1	1
Program Management	Program Management	PG Maintain State Plan	PG06 Maintain State Plan	1	1
Program Management	Program Management	PG Formulate Budget	PG07 Formulate Budget	1	1
Program Management	Program Management	PG Manage FFP for MMIS	PG08 Manage FFP for MMIS	1	1
Program Management	Program Management	PG Manage F-MAP	PG09 Manage F-MAP	1	1
Program Management	Program Management	PG Manage State Funds	PG10 Manage State Funds	1	1
Program Management	Program Management	PG Manage 1099s	PG11 Manage 1099s	2	2
Program Management	Program Management	PG Generate Financial and Program Analysis/Report	PG12 Generate Financial and Program Analysis/Report	1	1
Program Management	Program Management	PG Maintain Benefits/Reference Information	PG13 Maintain Benefits/Reference Information	1	1
Program Management	Program Management	PG Manage Program Information	PG14 Manage Program Information	1	1
Program Management	Program Management	PG Perform Accounting Functions	PG15 Perform Accounting Functions	1	1
Program Management	Program Management	PG Develop and Manage Performance Measures and Reporting	PG16 Develop and Manage Performance Measures and Reporting	1	1
Program Management	Program Management	PG Monitor Performance and Business Activity	PG17 Monitor Performance and Business Activity	1	1
Program Management	Program Management	PG Draw and Report FFP	PG18 Draw and Report FFP	1	1
Program Management	Program Management	PG Manage FFP for Services	PG19 Manage FFP for Services	1	1
Business Management					

MITA BUSINESS AREA	ALABAMA BUSINESS AREA	MITA BUSINESS PROCESS	ALABAMA BUSINESS PROCESS	AS IS LEVEL OF BUSINESS CAPABILITY	TO BE LEVEL OF BUSINESS CAPABILITY
Business Relationship Management	Business Relationship Management	BR Establish Business Relationship	BR01 Establish Business Relationship	1	1
Business Relationship Management	Business Relationship Management	BR Manage Business Relationship	BR02 Manage Business Relationship	1	1
Business Relationship Management	Business Relationship Management	BR Terminate Business Relationship	BR03 Terminate Business Relationship	1	1
Business Relationship Management	Business Relationship Management	BR Manage Business Relationship Communication	BR04 Manage Business Relationship Communication	1	1
Program Integrity					
Program Integrity Management	Program Integrity Management	PI Identify Candidate Case	PIM01 Identify Candidate Case	1	1
Program Integrity Management	Program Integrity Management	PI Manage Case	PIM02 Manage Case	1	1
Care Management					
Care Management	Care Management	CM Establish Case	CM01 Establish Case	1	1
Care Management	Care Management	CM Manage Case	CM02 Manage Case	1	1
Care Management	Care Management	CM Manage Medicaid Population Health	CM03 Manage Medicaid Population Health	1	1
Care Management	Care Management	CM Manage Registry	CM04 Manage Registry	N/A	N/A

Note this spreadsheet is for infomational purposes only. The actual spreadsheet will be provided at the Pre Bidders Conference.

Bidder's Name:										
Project Name	Client Information (name, address, fax, phone and email)	Client Contact Information (name, address, fax, phone and email)	MMIS	Summary	Original Start Date	Actual Start Date	Original End Date	Actual End Date	Original Scope and On Budget	Litigation

Note this				
Bidder's Name:				
Project Name	**Contract Changes or Amendments**	**If the project was not on schedule at the time of contract changes or amendments, how far behind was the project?**	**Prime or Subcontrator**	**Other Information**

Note this spreadsheet is for infomational purposes only. The actual spreadsheet will be provided at the Pre Bidders Conference.

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Pricing Schedule A (I) - To be completed by Incumbent Vendor only
Incumbent Vendor Evaluated Price

Month	Contract Item	Price	Factor	Evaluated Price
1	**Enhancements Implementation Phase Project Start-up (Sch B(I))**	$ -	1.000000	$ -
2	**Enhancement Implementation Phase Requirement Definition (Sch B(I))**	$ -	0.995851	$ -
3	**Enhancement Implementation Phase Construction and Testing (Sch B(I))**	$ -	0.991718	$ -
4			0.987603	
5	**Enhancement Implementation Testing (Sch B(I))**	$ -	0.983506	$ -
6	**Enhancements Implementation Phase Implementation (Sch B(I))**	$ -	0.979425	$ -
7			0.975361	
8			0.971313	
9			0.967283	
10			0.963269	
11			0.959272	
12			0.955292	
13			0.951328	
14			0.947381	
15			0.943450	
16			0.939535	
17			0.935637	
18			0.931754	
19	Year 1 - Total Monthly Price from Sch C(I)	$ -	0.927888	$ -
19	Extra Contractual Services Sch-D(I)	$ -	0.927888	$ -
20	Year 1 - Total Monthly Price from Sch C(I)	$ -	0.924038	$ -
20	Extra Contractual Services Sch-D(I)	$ -	0.924038	$ -
21	Year 1 - Total Monthly Price from Sch C(I)	$ -	0.920204	$ -
21	Extra Contractual Services Sch-D(I)	$ -	0.920204	$ -
22	Year 1 - Total Monthly Price from Sch C(I)	$ -	0.916385	$ -
22	Extra Contractual Services Sch-D(I)	$ -	0.916385	$ -
23	Year 1 - Total Monthly Price from Sch C(I)	$ -	0.912583	$ -
23	Extra Contractual Services Sch-D(I)	$ -	0.912583	$ -
24	Year 1 - Total Monthly Price from Sch C(I)	$ -	0.908796	$ -
24	Extra Contractual Services Sch-D(I)	$ -	0.908796	$ -
25	Year 1 - Total Monthly Price from Sch C(I)	$ -	0.905025	$ -
25	Extra Contractual Services Sch-D(I)	$ -	0.905025	$ -

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Pricing Schedule A (I) - To be completed by Incumbent Vendor only
Incumbent Vendor Evaluated Price

Month	Contract Item	Price	Factor	Evaluated Price
26	Year 1 - Total Monthly Price from Sch C(I)	$ -	0.901270	$ -
26	Extra Contractual Services Sch-D(I)	$ -	0.901270	$ -
27	Year 1 - Total Monthly Price from Sch C(I)	$ -	0.897530	$ -
27	Extra Contractual Services Sch-D(I)	$ -	0.897530	$ -
28	Year 1 - Total Monthly Price from Sch C(I)	$ -	0.893806	$ -
28	Extra Contractual Services Sch-D(I)	$ -	0.893806	$ -
29	Year 1 - Total Monthly Price from Sch C(I)	$ -	0.890097	$ -
29	Extra Contractual Services Sch-D(I)	$ -	0.890097	$ -
30	Year 1 - Total Monthly Price from Sch C(I)	$ -	0.886404	$ -
30	Extra Contractual Services Sch-D(I)	$ -	0.886404	$ -
31	Year 2 - Total Monthly Price from Sch C(I)	$ -	0.882726	$ -
31	Extra Contractual Services Sch-D(I)	$ -	0.882726	$ -
32	Year 2 - Total Monthly Price from Sch C(I)	$ -	0.879063	$ -
32	Extra Contractual Services Sch-D(I)	$ -	0.879063	$ -
33	Year 2 - Total Monthly Price from Sch C(I)	$ -	0.875416	$ -
33	Extra Contractual Services Sch-D(I)	$ -	0.875416	$ -
34	Year 2 - Total Monthly Price from Sch C(I)	$ -	0.871783	$ -
34	Extra Contractual Services Sch-D(I)	$ -	0.871783	$ -
35	Year 2 - Total Monthly Price from Sch C(I)	$ -	0.868166	$ -
35	Extra Contractual Services Sch-D(I)	$ -	0.868166	$ -
36	Year 2 - Total Monthly Price from Sch C(I)	$ -	0.864564	$ -
36	Extra Contractual Services Sch-D(I)	$ -	0.864564	$ -
37	Year 2 - Total Monthly Price from Sch C(I)	$ -	0.860976	$ -
37	Extra Contractual Services Sch-D(I)	$ -	0.860976	$ -
38	Year 2 - Total Monthly Price from Sch C(I)	$ -	0.857404	$ -
38	Extra Contractual Services Sch-D(I)	$ -	0.857404	$ -
39	Year 2 - Total Monthly Price from Sch C(I)	$ -	0.853846	$ -
39	Extra Contractual Services Sch-D(I)	$ -	0.853846	$ -
40	Year 2 - Total Monthly Price from Sch C(I)	$ -	0.850303	$ -
40	Extra Contractual Services Sch-D(I)	$ -	0.850303	$ -
41	Year 2 - Total Monthly Price from Sch C(I)	$ -	0.846775	$ -
41	Extra Contractual Services Sch-D(I)	$ -	0.846775	$ -
42	Year 2 - Total Monthly Price from Sch C(I)	$ -	0.843261	$ -
42	Extra Contractual Services Sch-D(I)	$ -	0.843261	$ -
43	Year 3 - Total Monthly Price from Sch C(I)	$ -	0.839762	$ -
43	Extra Contractual Services Sch-D(I)	$ -	0.839762	$ -
44	Year 3 - Total Monthly Price from Sch C(I)	$ -	0.836278	$ -
44	Extra Contractual Services Sch-D(I)	$ -	0.836278	$ -
45	Year 3 - Total Monthly Price from Sch C(I)	$ -	0.832808	$ -
45	Extra Contractual Services Sch-D(I)	$ -	0.832808	$ -
46	Year 3 - Total Monthly Price from Sch C(I)	$ -	0.829352	$ -
46	Extra Contractual Services Sch-D(I)	$ -	0.829352	$ -
47	Year 3 - Total Monthly Price from Sch C(I)	$ -	0.825911	$ -
47	Extra Contractual Services Sch-D(I)	$ -	0.825911	$ -

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Pricing Schedule A (I) - To be completed by Incumbent Vendor only
Incumbent Vendor Evaluated Price

Month	Contract Item	Price	Factor	Evaluated Price
48	Year 3 - Total Monthly Price from Sch C(I)	$ -	0.822484	$ -
48	Extra Contractual Services Sch-D(I)	$ -	0.822484	$ -
49	Year 3 - Total Monthly Price from Sch C(I)	$ -	0.819071	$ -
49	Extra Contractual Services Sch-D(I)	$ -	0.819071	$ -
50	Year 3 - Total Monthly Price from Sch C(I)	$ -	0.815672	$ -
50	Extra Contractual Services Sch-D(I)	$ -	0.815672	$ -
51	Year 3 - Total Monthly Price from Sch C(I)	$ -	0.812288	$ -
51	Extra Contractual Services Sch-D(I)	$ -	0.812288	$ -
52	Year 3 - Total Monthly Price from Sch C(I)	$ -	0.808917	$ -
52	Extra Contractual Services Sch-D(I)	$ -	0.808917	$ -
53	Year 3 - Total Monthly Price from Sch C(I)	$ -	0.805561	$ -
53	Extra Contractual Services Sch-D(I)	$ -	0.805561	$ -
54	Year 3 - Total Monthly Price from Sch C(I)	$ -	0.802218	$ -
54	Extra Contractual Services Sch-D(I)	$ -	0.802218	$ -
55	Year 4 - Total Monthly Price from Sch C(I)	$ -	0.798890	$ -
55	Extra Contractual Services Sch-D(I)	$ -	0.798890	$ -
56	Year 4 - Total Monthly Price from Sch C(I)	$ -	0.795575	$ -
56	Extra Contractual Services Sch-D(I)	$ -	0.795575	$ -
57	Year 4 - Total Monthly Price from Sch C(I)	$ -	0.792274	$ -
57	Extra Contractual Services Sch-D(I)	$ -	0.792274	$ -
58	Year 4 - Total Monthly Price from Sch C(I)	$ -	0.788986	$ -
58	Extra Contractual Services Sch-D(I)	$ -	0.788986	$ -
59	Year 4 - Total Monthly Price from Sch C(I)	$ -	0.785712	$ -
59	Extra Contractual Services Sch-D(I)	$ -	0.785712	$ -
60	Year 4 - Total Monthly Price from Sch C(I)	$ -	0.782452	$ -
60	Extra Contractual Services Sch-D(I)	$ -	0.782452	$ -
61	Year 4 - Total Monthly Price from Sch C(I)	$ -	0.779205	$ -
61	Extra Contractual Services Sch-D(I)	$ -	0.779205	$ -
62	Year 4 - Total Monthly Price from Sch C(I)	$ -	0.775972	$ -
62	Extra Contractual Services Sch-D(I)	$ -	0.775972	$ -
63	Year 4 - Total Monthly Price from Sch C(I)	$ -	0.772752	$ -
63	Extra Contractual Services Sch-D(I)	$ -	0.772752	$ -
64	Year 4 - Total Monthly Price from Sch C(I)	$ -	0.769546	$ -
64	Extra Contractual Services Sch-D(I)	$ -	0.769546	$ -
65	Year 4 - Total Monthly Price from Sch C(I)	$ -	0.766353	$ -
65	Extra Contractual Services Sch-D(I)	$ -	0.766353	$ -
66	Year 4 - Total Monthly Price from Sch C(I)	$ -	0.763173	$ -
66	Extra Contractual Services Sch-D(I)	$ -	0.763173	$ -
67	Year 5 - Total Monthly Price from Sch C(I)	$ -	0.760006	$ -
67	Extra Contractual Services Sch-D(I)	$ -	0.760006	$ -
68	Year 5 - Total Monthly Price from Sch C(I)	$ -	0.756853	$ -
68	Extra Contractual Services Sch-D(I)	$ -	0.756853	$ -
69	Year 5 - Total Monthly Price from Sch C(I)	$ -	0.753712	$ -
69	Extra Contractual Services Sch-D(I)	$ -	0.753712	$ -

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Pricing Schedule A (I) - To be completed by Incumbent Vendor only
Incumbent Vendor Evaluated Price

Month	Contract Item	Price	Factor	Evaluated Price
70	Year 5 - Total Monthly Price from Sch C(I)	$ -	0.750585	$ -
70	Extra Contractual Services Sch-D(I)	$ -	0.750585	$ -
71	Year 5 - Total Monthly Price from Sch C(I)	$ -	0.747470	$ -
71	Extra Contractual Services Sch-D(I)	$ -	0.747470	$ -
72	Year 5 - Total Monthly Price from Sch C(I)	$ -	0.744369	$ -
72	Extra Contractual Services Sch-D(I)	$ -	0.744369	$ -
73	Year 5 - Total Monthly Price from Sch C(I)	$ -	0.741280	$ -
73	Extra Contractual Services Sch-D(I)	$ -	0.741280	$ -
74	Year 5 - Total Monthly Price from Sch C(I)	$ -	0.738204	$ -
74	Extra Contractual Services Sch-D(I)	$ -	0.738204	$ -
75	Year 5 - Total Monthly Price from Sch C(I)	$ -	0.735141	$ -
75	Extra Contractual Services Sch-D(I)	$ -	0.735141	$ -
76	Year 5 - Total Monthly Price from Sch C(I)	$ -	0.732091	$ -
76	Extra Contractual Services Sch-D(I)	$ -	0.732091	$ -
77	Year 5 - Total Monthly Price from Sch C(I)	$ -	0.729053	$ -
77	Extra Contractual Services Sch-D(I)	$ -	0.729053	$ -
78	Year 5 - Total Monthly Price from Sch C(I)	$ -	0.726028	$ -
78	Extra Contractual Services Sch-D(I)	$ -	0.726028	$ -
79	Year 6 - Total Monthly Price from Sch C(I)	$ -	0.723015	$ -
79	Extra Contractual Services Sch-D(I)	$ -	0.723015	$ -
80	Year 6 - Total Monthly Price from Sch C(I)	$ -	0.720015	$ -
80	Extra Contractual Services Sch-D(I)	$ -	0.720015	$ -
81	Year 6 - Total Monthly Price from Sch C(I)	$ -	0.717028	$ -
81	Extra Contractual Services Sch-D(I)	$ -	0.717028	$ -
82	Year 6 - Total Monthly Price from Sch C(I)	$ -	0.714052	$ -
82	Extra Contractual Services Sch-D(I)	$ -	0.714052	$ -
83	Year 6 - Total Monthly Price from Sch C(I)	$ -	0.711090	$ -
83	Extra Contractual Services Sch-D(I)	$ -	0.711090	$ -
84	Year 6 - Total Monthly Price from Sch C(I)	$ -	0.708139	$ -
84	Extra Contractual Services Sch-D(I)	$ -	0.708139	$ -
85	Year 6 - Total Monthly Price from Sch C(I)	$ -	0.705201	$ -
85	Extra Contractual Services Sch-D(I)	$ -	0.705201	$ -
86	Year 6 - Total Monthly Price from Sch C(I)	$ -	0.702275	$ -
86	Extra Contractual Services Sch-D(I)	$ -	0.702275	$ -
87	Year 6 - Total Monthly Price from Sch C(I)	$ -	0.699361	$ -
87	Extra Contractual Services Sch-D(I)	$ -	0.699361	$ -
88	Year 6 - Total Monthly Price from Sch C(I)	$ -	0.696459	$ -
88	Extra Contractual Services Sch-D(I)	$ -	0.696459	$ -
89	Year 6 - Total Monthly Price from Sch C(I)	$ -	0.693569	$ -
89	Extra Contractual Services Sch-D(I)	$ -	0.693569	$ -
90	Year 6 - Total Monthly Price from Sch C(I)	$ -	0.690691	$ -
90	Extra Contractual Services Sch-D(I)	$ -	0.690691	$ -
91	Year 7 - Total Monthly Price from Sch C(I)	$ -	0.687825	$ -
91	Extra Contractual Services Sch-D(I)	$ -	0.687825	$ -

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Pricing Schedule A (I) - To be completed by Incumbent Vendor only
Incumbent Vendor Evaluated Price

Month	Contract Item	Price	Factor	Evaluated Price
92	Year 7 - Total Monthly Price from Sch C(I)	$ -	0.684971	$ -
92	Extra Contractual Services Sch-D(I)	$ -	0.684971	$ -
93	Year 7 - Total Monthly Price from Sch C(I)	$ -	0.682129	$ -
93	Extra Contractual Services Sch-D(I)	$ -	0.682129	$ -
94	Year 7 - Total Monthly Price from Sch C(I)	$ -	0.679298	$ -
94	Extra Contractual Services Sch-D(I)	$ -	0.679298	$ -
95	Year 7 - Total Monthly Price from Sch C(I)	$ -	0.676480	$ -
95	Extra Contractual Services Sch-D(I)	$ -	0.676480	$ -
96	Year 7 - Total Monthly Price from Sch C(I)	$ -	0.673673	$ -
96	Extra Contractual Services Sch-D(I)	$ -	0.673673	$ -
97	Year 7 - Total Monthly Price from Sch C(I)	$ -	0.670877	$ -
97	Extra Contractual Services Sch-D(I)	$ -	0.670877	$ -
98	Year 7 - Total Monthly Price from Sch C(I)	$ -	0.668094	$ -
98	Extra Contractual Services Sch-D(I)	$ -	0.668094	$ -
99	Year 7 - Total Monthly Price from Sch C(I)	$ -	0.665321	$ -
99	Extra Contractual Services Sch-D(I)	$ -	0.665321	$ -
100	Year 7 - Total Monthly Price from Sch C(I)	$ -	0.662561	$ -
100	Extra Contractual Services Sch-D(I)	$ -	0.662561	$ -
101	Year 7 - Total Monthly Price from Sch C(I)	$ -	0.659812	$ -
101	Extra Contractual Services Sch-D(I)	$ -	0.659812	$ -
102	Year 7 - Total Monthly Price from Sch C(I)	$ -	0.657074	$ -
102	Extra Contractual Services Sch-D(I)	$ -	0.657074	$ -

TOTAL EVALUATED PRICE $ -

Note: Do not make entry in shaded area.

Signature:_____ Date:_____

	State of Alabama **Medicaid Management Information System** **INCUMBENT VENDOR ENHANCEMENTS IMPLEMENTATION PHASE (EIP) DELIVERABLES COSTS**			
	SCHEDULE B(I) - To be completed by Incumbent Vendor Only			
EIP PHASE	All deliverables must be "APPROVED" by the Medicaid ITB Project Manager and/or the Executive Steering Committee before payment is made to the Awarded Vendor on a deliverable. The deliverables below are to be priced based on the Bidder's bid for the final approved deliverable within each stage. Enter bid price in column D. The total fixed price on any one phase cannot exceed 25 percent of the cost for the entire Enhancements Implementation Phase	**DELIVERABLE FIXED PRICE**	**TOTAL FIXED PRICE**	
EIP Startup Deliverables	**DELIVERABLES**			
	Final Work Plan		$ -	
	Project Organization and Staffing Plan	$ -		
	Risk Management Plan	$ -		
	Communication Plan	$ -		
	Security Plan	$ -		
	Detailed Implementation Schedule	$ -	$ -	
	Master Test Plan	$ -	$ -	
	Project Charter		$ -	
	Project Kick-off Meeting	$ -		
	Project Orientation	$ -		
	Quality Management Plan	$ -	$ -	
	Issue Management Plan	$ -	$ -	
	Deliverable Definition Documents	$ -	$ -	
	Bi-Weekly Status Reports	$ -	$ -	
	Enhancement Plan		$ -	
	Configuration Management Plan	$ -		
	Requirements Traceability Matrix	$ -	$ -	
Total Fixed *Price of all EIP Startup Phase Deliverables (Enter amount in Schdule A(I), Month 1, Sch-B(I) Price)				$ -
EIP Requirements Definition Deliverables				

	State of Alabama **Medicaid Management Information System** **INCUMBENT VENDOR ENHANCEMENTS IMPLEMENTATION PHASE (EIP) DELIVERABLES COSTS**			
	SCHEDULE B(I) - To be completed by Incumbent Vendor Only			
EIP PHASE	All deliverables must be "APPROVED" by the Medicaid ITB Project Manager and/or the Executive Steering Committee before payment is made to the Awarded Vendor on a deliverable. The deliverables below are to be priced based on the Bidder's bid for the final approved deliverable within each stage. Enter bid price in column D. The total fixed price on any one phase cannot exceed 25 percent of the cost for the entire Enhancements Implementation Phase	**DELIVERABLE FIXED PRICE**	**TOTAL FIXED PRICE**	
	Enhancement Design Documents	$ -	$ -	
	JAD Sessions		$ -	
	JAD Meeting Minutes	$ -		
	Requirements document for each enhancement	$ -		
	Updated ITB requirements	$ -		
	Detail Design Document		$ -	
	Enhancement Detail Design Documents	$ -		
	Ancillary enhancement Design Detail Documents	$ -		
	Data Conversion Documents	$ -	$ -	
	Summary of Enhancement Changes Report	$ -	$ -	
Total Fixed *Price of all EIP Requirements Definition Phase Deliverables (Enter amount in Schdule A(I), Month 2, Sch-B(I) Price)				$ -
EIP Construction Deliverables				
	Construction		$ -	
	Peer Reviews and Walk-through documents	$ -		
	Unit and Subsystem Test Results	$ -		
	Training Plan	$ -	$ -	
	EIP Implementation Plan	$ -	$ -	
	System Documentation		$ -	
	Draft Manuals and documentation	$ -		
	Test Plans	$ -	$ -	

	State of Alabama **Medicaid Management Information System** **INCUMBENT VENDOR ENHANCEMENTS IMPLEMENTATION PHASE (EIP) DELIVERABLES COSTS**			
	SCHEDULE B(I) - To be completed by Incumbent Vendor Only			
EIP PHASE	All deliverables must be "APPROVED" by the Medicaid ITB Project Manager and/or the Executive Steering Committee before payment is made to the Awarded Vendor on a deliverable. The deliverables below are to be priced based on the Bidder's bid for the final approved deliverable within each stage. Enter bid price in column D. The total fixed price on any one phase cannot exceed 25 percent of the cost for the entire Enhancements Implementation Phase	**DELIVERABLE FIXED PRICE**	**TOTAL FIXED PRICE**	
	Vendor Certification in writing that the AMMIS is ready for the test Phase	$ -	$ -	
Total Fixed *Price of all EIP Contruction Phase Deliverables (Enter amount in Schdule A(I), Month 3, Sch-B(N) Price)				$ -
EIP Test Phase Deliverables				
	System Test Results	$ -	$ -	
	User Acceptance Test Complete	$ -	$ -	
	Regression Test Results	$ -	$ -	
	Stress Test Results	$ -	$ -	
Total Fixed *Price of all EIP Test Phase Deliverables (Enter amount in Schdule A(I), Month 5, Sch-B(I) Price)				$ -
EIP Implementation Phase Deliverables				
	Final Preparations		$ -	
	Final Version of all Deliverables	$ -		
	Ensure the AMMIS has the most current version of software and data	$ -		
	Prepare and deliver notice to providers concerning transition activities	$ -		
	Conduct Provider Training	$ -		

	State of Alabama **Medicaid Management Information System** **INCUMBENT VENDOR ENHANCEMENTS IMPLEMENTATION PHASE (EIP) DELIVERABLES COSTS**			
	SCHEDULE B(I) - To be completed by Incumbent Vendor Only			
EIP PHASE	All deliverables must be "APPROVED" by the Medicaid ITB Project Manager and/or the Executive Steering Committee before payment is made to the Awarded Vendor on a deliverable. The deliverables below are to be priced based on the Bidder's bid for the final approved deliverable within each stage. Enter bid price in column D. The total fixed price on any one phase cannot exceed 25 percent of the cost for the entire Enhancements Implementation Phase	**DELIVERABLE FIXED PRICE**	**TOTAL FIXED PRICE**	
	Conduct training for Vendor and Agency Staff	$ -		
	Conduct Call Center and Support Training	$ -		
	Distribute Alabama unique forms	$ -		
	Prepare, print or burn and deliver all user, system and provider manuals and documentation	$ -		
	Final update to all documentation	$ -		
	Completion of all activities in the training and implementation plans	$ -		
	Completion of all EIP deliverables	$ -		
	Installation of the Manuals and Documentation System Operations Procedures on-line or on the web.	$ -		
	Implement Enhancements		$ -	
	Begin Processing Claims for all claim types	$ -		
	Agency acceptance of Enhancements	$ -		
	Post Implementation Deliverables		$ -	
	Approval of AMMIS financial data and claims inventory balancing procedures	$ -		
	Approval that all claims types are processing at expected volumes and within the required time frames	$ -		
	Approval that all reports are being delivered as required	$ -		
Total Fixed *Price of EIP Implementation Phase Deliverables (Enter amount in Schdule A(I), Month 6, Sch-B(I) Price)				$ -

	State of Alabama **Medicaid Management Information System** **INCUMBENT VENDOR ENHANCEMENTS IMPLEMENTATION PHASE (EIP) DELIVERABLES COSTS**			
	SCHEDULE B(I) - To be completed by Incumbent Vendor Only			
EIP PHASE	All deliverables must be "APPROVED" by the Medicaid ITB Project Manager and/or the Executive Steering Committee before payment is made to the Awarded Vendor on a deliverable. The deliverables below are to be priced based on the Bidder's bid for the final approved deliverable within each stage. Enter bid price in column D. The total fixed price on any one phase cannot exceed 25 percent of the cost for the entire Enhancements Implementation Phase	**DELIVERABLE FIXED PRICE**	**TOTAL FIXED PRICE**	
Grand Total Fixed Price of all EIP Phases				$ -
* The total fixed price on any one phase cannot exceed 25 percent of the cost for the entire Enhancements Implementation Phase				
	Signature:_____	Date:_____		

	State of Alabama **Medicaid Management Information System** **INCUMBENT VENDOR ENHANCEMENTS IMPLEMENTATION PHASE (EIP) DELIVERABLES COSTS**			
	SCHEDULE B(I) - To be completed by Incumbent Vendor Only			
EIP PHASE	All deliverables must be "APPROVED" by the Medicaid ITB Project Manager and/or the Executive Steering Committee before payment is made to the Awarded Vendor on a deliverable. The deliverables below are to be priced based on the Bidder's bid for the final approved deliverable within each stage. Enter bid price in column D. The total fixed price on any one phase cannot exceed 25 percent of the cost for the entire Enhancements Implementation Phase	**DELIVERABLE FIXED PRICE**	**TOTAL FIXED PRICE**	

State of Alabama
Medicaid Management Information System
Pricing Schedule C(I)
Operations Cost
SCHEDULE C(I) is to be completed by Incumbent Vendor only

Year	Item	Price
1	Base Price Per Month **Total Monthly Price (Enter amount on Sch. A(I), Months 19-30, Sch-C(I) Price)**	$ -
2	Base Price Per Month **Total Monthly Price (Enter amount on Sch. A(I), Months 31-42, Sch-C(I) Price)**	$ -
3	Base Price Per Month **Total Monthly Price (Enter amount on Sch. A(I), Months 43-54, Sch-C(I) Price)**	$ -
4	Base Price Per Month **Total Monthly Price (Enter amount on Sch. A(I), Months 55-66, Sch-C(I) Price)**	$ -
5	Base Price Per Month **Total Monthly Price (Enter amount on Sch. A(I), Months 67-78, Sch-C(I) Price)**	$ -
6	Base Price Per Month **Total Monthly Price (Enter amount on Sch. A(I), Months 79-90, Sch-C(I) Price)**	$ -
7	Base Price Per Month **Total Monthly Price (Enter amount on Sch. A(I), Months 91-102, Sch-C(I) Price)**	$ -

*** For Evaluation Purposes Only.**

Signature:_____ Date:_____

State of Alabama
Medicaid Management Information System
Pricing Schedule D(I) - Summary Extra Contractural Services
SCHEDULE D(I) is to be completed by Incumbent Vendor only

Year 1 From Pricing Schedule D-2	$ -	Box 1
Average Monthly Cost (Divide Amount in Box 1 by 12) Enter Amount from Box 2 to Schedule A(I), Months 19-30	$ -	Box 2
Year 2 From Pricing Schedule D-3	$ -	Box 3
Average Monthly Cost (Divide Amount in Box 3 by 12) Enter Amount from Box 4 to Schedule A(I), Months 31-42	$ -	Box 4
Year 3 From Pricing Schedule D-4	$ -	Box 5
Average Monthly Cost (Divide Amount in Box 5 by 12) Enter Amount from Box 6 to Schedule A(I), Months 43-54	$ -	Box 6
Year 4 From Pricing Schedule D-5	$ -	Box 7
Average Monthly Cost (Divide Amount in Box 7 by 12) Enter Amount from Box 8 to Schedule A(I), Months 55-66	$ -	Box 8
Year 5 From Pricing Schedule D-6	$ -	Box 9
Average Monthly Cost (Divide Amount in Box 9 by 12) Enter Amount from Box 10 to Schedule A(I), Months 67-78	$ -	Box 10
Year 6 From Pricing Schedule D-7	$ -	Box 11
Average Monthly Cost (Divide Amount in Box 11 by 12) Enter Amount from Box 12 to Schedule A(I), Months 79-90	$ -	Box 12
Year 7 From Pricing Schedule D-8	$ -	Box 13
Average Monthly Cost (Divide Amount in Box 13 by 12) Enter Amount from Box 14 to Schedule A(I), Months 91-102	$ -	Box 14
TOTAL EXTRA CONTRACTURAL SERVICES COSTS (Informational Only) (Sum of Boxes 1, 3, 5, 7, 9,11, and 13)	$ -	

Signature: _____ Date: _____

State of Alabama
Medicaid Management Information System

Pricing Schedule D-2
Extra Contractual Services - Contract Year 1

	Personnel Category	Hourly Rate	Hours (See Note)	Evaluated Cost
1	EIS/DSS Technical Support	$ -	1,500	$ -
2	Senior Systems Analyst	$ -	1,500	$ -
3	Programmer Analyst	$ -	2,500	$ -
4	Junior Programmer Analyst	$ -	1,500	$ -
5	Project Analyst	$ -	3,500	$ -
6	Customer Relations Staff	$ -	2,000	$ -
7	Systems/Technical Support	$ -	250	$ -
8	Professional Staff (Nurses)	$ -	250	$ -
9	CPU Time	$ -	500	$ -

TOTAL EXTRA CONTRACTUAL SERVICES COSTS EXTENSION 1:	**$ -**

Enter on Sch-D-1, Box 1.

Note: Hours indicated are for evaluation purposes only.

Signature: _____ Date: _____

State of Alabama
Medicaid Management Information System

Pricing Schedule D-3
Extra Contractual Services - Contract Year 2

	Personnel Category	Hourly Rate	Hours (See Note)	Evaluated Cost
1	EIS/DSS Technical Support	$ -	1,500	$ -
2	Senior Systems Analyst	$ -	1,500	$ -
3	Programmer Analyst	$ -	2,500	$ -
4	Junior Programmer Analyst	$ -	1,500	$ -
5	Project Analyst	$ -	3,500	$ -
6	Customer Relations Staff	$ -	2,000	$ -
7	Systems/Technical Support	$ -	250	$ -
8	Professional Staff (Nurses)	$ -	250	$ -
9	CPU Time	$ -	500	$ -

TOTAL EXTRA CONTRACTUAL SERVICES COSTS EXTENSION 1:	**$ -**

Enter on Sch-D-1, Box 3.

Note: Hours indicated are for evaluation purposes only.

Signature: _____ Date: _____

State of Alabama
Medicaid Management Information System

Pricing Schedule D-4
Extra Contractual Services - Contract Year 3

	Personnel Category	Hourly Rate	Hours (See Note)	Evaluated Cost
1	EIS/DSS Technical Support	$ -	1,500	$ -
2	Senior Systems Analyst	$ -	1,500	$ -
3	Programmer Analyst	$ -	2,500	$ -
4	Junior Programmer Analyst	$ -	1,500	$ -
5	Project Analyst	$ -	3,500	$ -
6	Customer Relations Staff	$ -	2,000	$ -
7	Systems/Technical Support	$ -	250	$ -
8	Professional Staff (Nurses)	$ -	250	$ -
9	CPU Time	$ -	500	$ -

TOTAL EXTRA CONTRACTUAL SERVICES COSTS EXTENSION 1:	**$ -**

Enter on Sch-D-1, Box 5.

Note: Hours indicated are for evaluation purposes only.

Signature: _____ Date: _____

State of Alabama
Medicaid Management Information System

Pricing Schedule D-5
Extra Contractual Services - Contract Year 4

	Personnel Category	Hourly Rate	Hours (See Note)	Evaluated Cost
1	EIS/DSS Technical Support	$ -	1,500	$ -
2	Senior Systems Analyst	$ -	1,500	$ -
3	Programmer Analyst	$ -	2,500	$ -
4	Junior Programmer Analyst	$ -	1,500	$ -
5	Project Analyst	$ -	3,500	$ -
6	Customer Relations Staff	$ -	2,000	$ -
7	Systems/Technical Support	$ -	250	$ -
8	Professional Staff (Nurses)	$ -	250	$ -
9	CPU Time	$ -	500	$ -

TOTAL EXTRA CONTRACTUAL SERVICES COSTS EXTENSION 1:	**$ -**

Enter on Sch-D-1, Box 7.

Note: Hours indicated are for evaluation purposes only.

Signature: _____ Date: _____

State of Alabama
Medicaid Management Information System

Pricing Schedule D-6
Extra Contractual Services - Contract Year 5

	Personnel Category	Hourly Rate	Hours (See Note)	Evaluated Cost
1	EIS/DSS Technical Support	$ -	1,000	$ -
2	Senior Systems Analyst	$ -	1,000	$ -
3	Programmer Analyst	$ -	2,000	$ -
4	Junior Programmer Analyst	$ -	1,000	$ -
5	Project Analyst	$ -	2,000	$ -
6	Customer Relations Staff	$ -	2,000	$ -
7	Systems/Technical Support	$ -	250	$ -
8	Professional Staff (Nurses)	$ -	250	$ -
9	CPU Time	$ -	500	$ -

TOTAL EXTRA CONTRACTUAL SERVICES COSTS EXTENSION 1:	**$ -**

Enter on Sch-D-1, Box 9.

Note: Hours indicated are for evaluation purposes only.

Signature: _____ Date: _____

State of Alabama
Medicaid Management Information System

Pricing Schedule D-7
Extra Contractual Services - Contract Year 6

	Personnel Category	Hourly Rate	Hours (See Note)	Evaluated Cost
1	EIS/DSS Technical Support	$ -	1,000	$ -
2	Senior Systems Analyst	$ -	1,000	$ -
3	Programmer Analyst	$ -	2,000	$ -
4	Junior Programmer Analyst	$ -	1,000	$ -
5	Project Analyst	$ -	2,000	$ -
6	Customer Relations Staff	$ -	2,000	$ -
7	Systems/Technical Support	$ -	250	$ -
8	Professional Staff (Nurses)	$ -	250	$ -
9	CPU Time	$ -	500	$ -

TOTAL EXTRA CONTRACTUAL SERVICES COSTS EXTENSION 1:	**$ -**

Enter on Sch-D-1, Box 11.

Note: Hours indicated are for evaluation purposes only.

Signature: _____ Date: _____

State of Alabama
Medicaid Management Information System

Pricing Schedule D-8
Extra Contractual Services - Contract Year 7

	Personnel Category	Hourly Rate	Hours (See Note)	Evaluated Cost
1	EIS/DSS Technical Support	$ -	1,000	$ -
2	Senior Systems Analyst	$ -	1,000	$ -
3	Programmer Analyst	$ -	2,000	$ -
4	Junior Programmer Analyst	$ -	1,000	$ -
5	Project Analyst	$ -	2,000	$ -
6	Customer Relations Staff	$ -	2,000	$ -
7	Systems/Technical Support	$ -	250	$ -
8	Professional Staff (Nurses)	$ -	250	$ -
9	CPU Time	$ -	500	$ -

TOTAL EXTRA CONTRACTUAL SERVICES COSTS EXTENSION 1:	**$ -**

Enter on Sch-D-1, Box 13.

Note: Hours indicated are for evaluation purposes only.

Signature: _____ Date: _____

Note this spreadsheet is for infomational purposes only. The actual spreadsheet will be provided at the Pre Bidders Conference.

State of Alabama

Medicaid Management Information System

Pricing Schedule A (N)

Non-Incumbent Vendor Evaluated Price

Month	Contract Item	Price	Discount Factor	Evaluated Price
1	Operations Implementation Phase Project Start-up Sch B(N)	$ -	1.000000	$ -
2			0.995851	
3	Operations Implementation Phase Plan Sch B(N)	$ -	0.991718	$ -
4			0.987603	
5	Operations Implementation Phase Design Sch B(N)	$ -	0.983506	$ -
6			0.979425	
7	Operation Implementation Phase Construction and Testing Sch B(N)	$ -	0.975361	$ -
8			0.971313	
9			0.967283	
10	System Acceptance Testing Sch B(N)	$ -	0.963269	$ -
11	OIP Implementation Phase Deliverables	$ -	0.959272	$ -
12			0.955292	
13	Enhancements Implementation Phase Project Start-up Sch B(N)	$ -	0.951328	$ -
14	Enhancement Implementation Phase Requirement Definition Sch B(N)	$ -	0.947381	$ -
15	Enhancement Implementation Phase Construction and Testing Sch B(N)	$ -	0.943450	$ -
16			0.939535	
17	Enhancement Implementation Testing Sch B(N)	$ -	0.935637	$ -
18	Enhancements Implementation Phase Implementation Sch B(N)	$ -	0.931754	$ -
19	Year 1 - Total Monthly Price from Sch C(N)	$ -	0.927888	$ -
19	Extra Contractual Services Sch D-1(N)	$ -	0.927888	$ -
20	Year 1 - Total Monthly Price from Sch C(N)	$ -	0.924038	$ -
20	Extra Contractual Services Sch D-1(N)	$ -	0.924038	$ -
21	Year 1 - Total Monthly Price from Sch C(N)	$ -	0.920204	$ -
21	Extra Contractual Services Sch D-1(N)	$ -	0.920204	$ -
22	Year 1 - Total Monthly Price from Sch C(N)	$ -	0.916385	$ -
22	Extra Contractual Services Sch D-1(N)	$ -	0.916385	$ -
23	Year 1 - Total Monthly Price from Sch C(N)	$ -	0.912583	$ -
23	Extra Contractual Services Sch D-1(N)	$ -	0.912583	$ -
24	Year 1 - Total Monthly Price from Sch C(N)	$ -	0.908796	$ -
24	Extra Contractual Services Sch D-1(N)	$ -	0.908796	$ -
25	Year 1 - Total Monthly Price from Sch C(N)	$ -	0.905025	$ -
25	Extra Contractual Services Sch D-1(N)	$ -	0.905025	$ -
26	Year 1 - Total Monthly Price from Sch C(N)	$ -	0.901270	$ -
26	Extra Contractual Services Sch D-1(N)	$ -	0.901270	$ -
27	Year 1 - Total Monthly Price from Sch C(N)	$ -	0.897530	$ -
27	Extra Contractual Services Sch D-1(N)	$ -	0.897530	$ -
28	Year 1 - Total Monthly Price from Sch C(N)	$ -	0.893806	$ -
28	Extra Contractual Services Sch D-1(N)	$ -	0.893806	$ -
29	Year 1 - Total Monthly Price from Sch C(N)	$ -	0.890097	$ -
29	Extra Contractual Services Sch D-1(N)	$ -	0.890097	$ -
30	Year 1 - Total Monthly Price from Sch C(N)	$ -	0.886404	$ -
30	Extra Contractual Services Sch D-1(N)	$ -	0.886404	$ -
31	Year 2 - Total Monthly Price from Sch C(N)	$ -	0.882726	$ -
31	Extra Contractual Services Sch D-1(N)	$ -	0.882726	$ -
32	Year 2 - Total Monthly Price from Sch C(N)	$ -	0.879063	$ -

State of Alabama

Medicaid Management Information System

Pricing Schedule A (N)

Non-Incumbent Vendor Evaluated Price

Month	Contract Item	Price	Discount Factor	Evaluated Price
32	Extra Contractual Services Sch D-1(N)	$ -	0.879063	$ -
33	Year 2 - Total Monthly Price from Sch C(N)	$ -	0.875416	$ -
33	Extra Contractual Services Sch D-1(N)	$ -	0.875416	$ -
34	Year 2 - Total Monthly Price from Sch C(N)	$ -	0.871783	$ -
34	Extra Contractual Services Sch D-1(N)	$ -	0.871783	$ -
35	Year 2 - Total Monthly Price from Sch C(N)	$ -	0.868166	$ -
35	Extra Contractual Services Sch D-1(N)	$ -	0.868166	$ -
36	Year 2 - Total Monthly Price from Sch C(N)	$ -	0.864564	$ -
36	Extra Contractual Services Sch D-1(N)	$ -	0.864564	$ -
37	Year 2 - Total Monthly Price from Sch C(N)	$ -	0.860976	$ -
37	Extra Contractual Services Sch D-1(N)	$ -	0.860976	$ -
38	Year 2 - Total Monthly Price from Sch C(N)	$ -	0.857404	$ -
38	Extra Contractual Services Sch D-1(N)	$ -	0.857404	$ -
39	Year 2 - Total Monthly Price from Sch C(N)	$ -	0.853846	$ -
39	Extra Contractual Services Sch D-1(N)	$ -	0.853846	$ -
40	Year 2 - Total Monthly Price from Sch C(N)	$ -	0.850303	$ -
40	Extra Contractual Services Sch D-1(N)	$ -	0.850303	$ -
41	Year 2 - Total Monthly Price from Sch C(N)	$ -	0.846775	$ -
41	Extra Contractual Services Sch D-1(N)	$ -	0.846775	$ -
42	Year 2 - Total Monthly Price from Sch C(N)	$ -	0.843261	$ -
42	Extra Contractual Services Sch D-1(N)	$ -	0.843261	$ -
43	Year 3 - Total Monthly Price from Sch C(N)	$ -	0.839762	$ -
43	Extra Contractual Services Sch D-1(N)	$ -	0.839762	$ -
44	Year 3 - Total Monthly Price from Sch C(N)	$ -	0.836278	$ -
44	Extra Contractual Services Sch D-1(N)	$ -	0.836278	$ -
45	Year 3 - Total Monthly Price from Sch C(N)	$ -	0.832808	$ -
45	Extra Contractual Services Sch D-1(N)	$ -	0.832808	$ -
46	Year 3 - Total Monthly Price from Sch C(N)	$ -	0.829352	$ -
46	Extra Contractual Services Sch D-1(N)	$ -	0.829352	$ -
47	Year 3 - Total Monthly Price from Sch C(N)	$ -	0.825911	$ -
47	Extra Contractual Services Sch D-1(N)	$ -	0.825911	$ -
48	Year 3 - Total Monthly Price from Sch C(N)	$ -	0.822484	$ -
48	Extra Contractual Services Sch D-1(N)	$ -	0.822484	$ -
49	Year 3 - Total Monthly Price from Sch C(N)	$ -	0.819071	$ -
49	Extra Contractual Services Sch D-1(N)	$ -	0.819071	$ -
50	Year 3 - Total Monthly Price from Sch C(N)	$ -	0.815672	$ -
50	Extra Contractual Services Sch D-1(N)	$ -	0.815672	$ -
51	Year 3 - Total Monthly Price from Sch C(N)	$ -	0.812288	$ -
51	Extra Contractual Services Sch D-1(N)	$ -	0.812288	$ -
52	Year 3 - Total Monthly Price from Sch C(N)	$ -	0.808917	$ -
52	Extra Contractual Services Sch D-1(N)	$ -	0.808917	$ -
53	Year 3 - Total Monthly Price from Sch C(N)	$ -	0.805561	$ -
53	Extra Contractual Services Sch D-1(N)	$ -	0.805561	$ -
54	Year 3 - Total Monthly Price from Sch C(N)	$ -	0.802218	$ -
54	Extra Contractual Services Sch D-1(N)	$ -	0.802218	$ -
55	Year 4 - Total Monthly Price from Sch C(N)	$ -	0.798890	$ -
55	Extra Contractual Services Sch D-1(N)	$ -	0.798890	$ -
56	Year 4 - Total Monthly Price from Sch C(N)	$ -	0.795575	$ -
56	Extra Contractual Services Sch D-1(N)	$ -	0.795575	$ -
57	Year 4 - Total Monthly Price from Sch C(N)	$ -	0.792274	$ -
57	Extra Contractual Services Sch D-1(N)	$ -	0.792274	$ -
58	Year 4 - Total Monthly Price from Sch C(N)	$ -	0.788986	$ -
58	Extra Contractual Services Sch D-1(N)	$ -	0.788986	$ -
59	Year 4 - Total Monthly Price from Sch C(N)	$ -	0.785712	$ -
59	Extra Contractual Services Sch D-1(N)	$ -	0.785712	$ -
60	Year 4 - Total Monthly Price from Sch C(N)	$ -	0.782452	$ -
60	Extra Contractual Services Sch D-1(N)	$ -	0.782452	$ -
61	Year 4 - Total Monthly Price from Sch C(N)	$ -	0.779205	$ -

State of Alabama

Medicaid Management Information System

Pricing Schedule A (N)

Non-Incumbent Vendor Evaluated Price

Month	Contract Item	Price	Discount Factor	Evaluated Price
61	Extra Contractual Services Sch D-1(N)	$ -	0.779205	$ -
62	Year 4 - Total Monthly Price from Sch C(N)	$ -	0.775972	$ -
62	Extra Contractual Services Sch D-1(N)	$ -	0.775972	$ -
63	Year 4 - Total Monthly Price from Sch C(N)	$ -	0.772752	$ -
63	Extra Contractual Services Sch D-1(N)	$ -	0.772752	$ -
64	Year 4 - Total Monthly Price from Sch C(N)	$ -	0.769546	$ -
64	Extra Contractual Services Sch D-1(N)	$ -	0.769546	$ -
65	Year 4 - Total Monthly Price from Sch C(N)	$ -	0.766353	$ -
65	Extra Contractual Services Sch D-1(N)	$ -	0.766353	$ -
66	Year 4 - Total Monthly Price from Sch C(N)	$ -	0.763173	$ -
66	Extra Contractual Services Sch D-1(N)	$ -	0.763173	$ -
67	Year 5 - Total Monthly Price from Sch C(N)	$ -	0.760006	$ -
67	Extra Contractual Services Sch D-1(N)	$ -	0.760006	$ -
68	Year 5 - Total Monthly Price from Sch C(N)	$ -	0.756853	$ -
68	Extra Contractual Services Sch D-1(N)	$ -	0.756853	$ -
69	Year 5 - Total Monthly Price from Sch C(N)	$ -	0.753712	$ -
69	Extra Contractual Services Sch D-1(N)	$ -	0.753712	$ -
70	Year 5 - Total Monthly Price from Sch C(N)	$ -	0.750585	$ -
70	Extra Contractual Services Sch D-1(N)	$ -	0.750585	$ -
71	Year 5 - Total Monthly Price from Sch C(N)	$ -	0.747470	$ -
71	Extra Contractual Services Sch D-1(N)	$ -	0.747470	$ -
72	Year 5 - Total Monthly Price from Sch C(N)	$ -	0.744369	$ -
72	Extra Contractual Services Sch D-1(N)	$ -	0.744369	$ -
73	Year 5 - Total Monthly Price from Sch C(N)	$ -	0.741280	$ -
73	Extra Contractual Services Sch D-1(N)	$ -	0.741280	$ -
74	Year 5 - Total Monthly Price from Sch C(N)	$ -	0.738204	$ -
74	Extra Contractual Services Sch D-1(N)	$ -	0.738204	$ -
75	Year 5 - Total Monthly Price from Sch C(N)	$ -	0.735141	$ -
75	Extra Contractual Services Sch D-1(N)	$ -	0.735141	$ -
76	Year 5 - Total Monthly Price from Sch C(N)	$ -	0.732091	$ -
76	Extra Contractual Services Sch D-1(N)	$ -	0.732091	$ -
77	Year 5 - Total Monthly Price from Sch C(N)	$ -	0.729053	$ -
77	Extra Contractual Services Sch D-1(N)	$ -	0.729053	$ -
78	Year 5 - Total Monthly Price from Sch C(N)	$ -	0.726028	$ -
78	Extra Contractual Services Sch D-1(N)	$ -	0.726028	$ -
79	Year 6 - Total Monthly Price from Sch C(N)	$ -	0.723015	$ -
79	Extra Contractual Services Sch D-1(N)	$ -	0.723015	$ -
80	Year 6 - Total Monthly Price from Sch C(N)	$ -	0.720015	$ -
80	Extra Contractual Services Sch D-1(N)	$ -	0.720015	$ -
81	Year 6 - Total Monthly Price from Sch C(N)	$ -	0.717028	$ -
81	Extra Contractual Services Sch D-1(N)	$ -	0.717028	$ -
82	Year 6 - Total Monthly Price from Sch C(N)	$ -	0.714052	$ -
82	Extra Contractual Services Sch D-1(N)	$ -	0.714052	$ -
83	Year 6 - Total Monthly Price from Sch C(N)	$ -	0.711090	$ -
83	Extra Contractual Services Sch D-1(N)	$ -	0.711090	$ -
84	Year 6 - Total Monthly Price from Sch C(N)	$ -	0.708139	$ -
84	Extra Contractual Services Sch D-1(N)	$ -	0.708139	$ -
85	Year 6 - Total Monthly Price from Sch C(N)	$ -	0.705201	$ -
85	Extra Contractual Services Sch D-1(N)	$ -	0.705201	$ -
86	Year 6 - Total Monthly Price from Sch C(N)	$ -	0.702275	$ -
86	Extra Contractual Services Sch D-1(N)	$ -	0.702275	$ -
87	Year 6 - Total Monthly Price from Sch C(N)	$ -	0.699361	$ -
87	Extra Contractual Services Sch D-1(N)	$ -	0.699361	$ -
88	Year 6 - Total Monthly Price from Sch C(N)	$ -	0.696459	$ -
88	Extra Contractual Services Sch D-1(N)	$ -	0.696459	$ -
89	Year 6 - Total Monthly Price from Sch C(N)	$ -	0.693569	$ -
89	Extra Contractual Services Sch D-1(N)	$ -	0.693569	$ -
90	Year 6 - Total Monthly Price from Sch C(N)	$ -	0.690691	$ -

State of Alabama

Medicaid Management Information System

Pricing Schedule A (N)

Non-Incumbent Vendor Evaluated Price

Month	Contract Item	Price	Discount Factor	Evaluated Price
90	Extra Contractual Services Sch D-1(N)	$ -	0.690691	$ -
91	Year 7 - Total Monthly Price from Sch C(N)	$ -	0.687825	$ -
91	Extra Contractual Services Sch D-1(N)	$ -	0.687825	$ -
92	Year 7 - Total Monthly Price from Sch C(N)	$ -	0.684971	$ -
92	Extra Contractual Services Sch D-1(N)	$ -	0.684971	$ -
93	Year 7 - Total Monthly Price from Sch C(N)	$ -	0.682129	$ -
93	Extra Contractual Services Sch D-1(N)	$ -	0.682129	$ -
94	Year 7 - Total Monthly Price from Sch C(N)	$ -	0.679298	$ -
94	Extra Contractual Services Sch D-1(N)	$ -	0.679298	$ -
95	Year 7 - Total Monthly Price from Sch C(N)	$ -	0.676480	$ -
95	Extra Contractual Services Sch D-1(N)	$ -	0.676480	$ -
96	Year 7 - Total Monthly Price from Sch C(N)	$ -	0.673673	$ -
96	Extra Contractual Services Sch D-1(N)	$ -	0.673673	$ -
97	Year 7 - Total Monthly Price from Sch C(N)	$ -	0.670877	$ -
97	Extra Contractual Services Sch D-1(N)	$ -	0.670877	$ -
98	Year 7 - Total Monthly Price from Sch C(N)	$ -	0.668094	$ -
98	Extra Contractual Services Sch D-1(N)	$ -	0.668094	$ -
99	Year 7 - Total Monthly Price from Sch C(N)	$ -	0.665321	$ -
99	Extra Contractual Services Sch D-1(N)	$ -	0.665321	$ -
100	Year 7 - Total Monthly Price from Sch C(N)	$ -	0.662561	$ -
100	Extra Contractual Services Sch D-1(N)	$ -	0.662561	$ -
101	Year 7 - Total Monthly Price from Sch C(N)	$ -	0.659812	$ -
101	Extra Contractual Services Sch D-1(N)	$ -	0.659812	$ -
102	Year 7 - Total Monthly Price from Sch C(N)	$ -	0.657074	$ -
102	Extra Contractual Services Sch D-1(N)	$ -	0.657074	$ -
	TOTAL EVALUATED PRICE			$ -
	Note: Do not make entry in shaded area.			
	Signature:_____	Date:_____		

	State of Alabama **Medicaid Management Information System** **SCHEDULE B(N) - To be complete by Non-Incumbent Vendor Only**			
	OPERATIONS IMPLEMENTATION PHASE (OIP) DELIVERABLES			
	All deliverables must be "APPROVED" by the Medicaid ITB Project Manager and/or the Executive Steering Committee before payment is made to the Awarded Vendor on a deliverable. The deliverables below are to be priced based on the Bidder's bid for the final approved deliverable within each stage. Enter bid price in column D. The total fixed price on any one phase cannot exceed 25 percent of the cost for the entire Operations Implementation Phase			
OIP PHASE	**DELIVERABLES**	**DELIVERABLE FIXED PRICE**	**TOTAL FIXED PRICE**	
OIP Project Startup	Final Work plan and Schedule		$ -	
	Project Organization and Staffing Plan	$ -		
	Risk Management Plan	$ -		
	Communication Plan	$ -		
	Security Plan	$ -		
	Detailed Implementation Schedule	$ -	$ -	
	Project Charter		$ -	
	Project Kick-off Meeting	$ -		
	Project Orientation	$ -		
	Vendor Tool Schedule	$ -		
	Quality Management Plan	$ -	$ -	
	Issue Management Plan	$ -	$ -	
	Deliverable Definition Documents	$ -	$ -	
	Bi-Weekly Status Reports	$ -	$ -	
	Completion of Agency Workspace	$ -	$ -	
	Establishment of Gateway to Agency	$ -	$ -	

	State of Alabama **Medicaid Management Information System** **SCHEDULE B(N) - To be complete by Non-Incumbent Vendor Only**			
	OPERATIONS IMPLEMENTATION PHASE (OIP) DELIVERABLES			
	All deliverables must be "APPROVED" by the Medicaid ITB Project Manager and/or the Executive Steering Committee before payment is made to the Awarded Vendor on a deliverable. The deliverables below are to be priced based on the Bidder's bid for the final approved deliverable within each stage. Enter bid price in column D. The total fixed price on any one phase cannot exceed 25 percent of the cost for the entire Operations Implementation Phase			
OIP PHASE	**DELIVERABLES**	**DELIVERABLE FIXED PRICE**	**TOTAL FIXED PRICE**	
Total Fixed *Price of all OIP Project Startup Deliverables (Enter amount in Schdule A(N), Month 1, Sch-B(N) Price)				$ -
OIP Transition Plan Deliverables				
	Transition Plan		$ -	
	System Interface Transition Plan	$ -		
	Ancillary Transition Plan	$ -		
	Master Test Plan	$ -	$ -	
	Vendor Tool Training	$ -	$ -	
	Issue Tracking Process	$ -	$ -	
	Requirements Traceability Matrix	$ -	$ -	
Total Fixed *Price of all OIP Transition Plan Deliverables (Enter amount in Schdule A(N), Month 3, Sch-B(N) Price)				$ -

	State of Alabama **Medicaid Management Information System** **SCHEDULE B(N) - To be complete by Non-Incumbent Vendor Only**			
	OPERATIONS IMPLEMENTATION PHASE (OIP) DELIVERABLES			
	All deliverables must be "APPROVED" by the Medicaid ITB Project Manager and/or the Executive Steering Committee before payment is made to the Awarded Vendor on a deliverable. The deliverables below are to be priced based on the Bidder's bid for the final approved deliverable within each stage. Enter bid price in column D. The total fixed price on any one phase cannot exceed 25 percent of the cost for the entire Operations Implementation Phase			
OIP PHASE	**DELIVERABLES**	**DELIVERABLE FIXED PRICE**	**TOTAL FIXED PRICE**	
OIP Design Deliverables	System Support and Transition Design Documents		$ -	
	System Interface Document	$ -		
	Data Conversion Document	$ -		
	Software Conversion Document	$ -		
	Configuration Management Plan	$ -		
	Operations Support and Transition Design Documents		$ -	
	Call Center Documents	$ -		
	Support and Operations Document	$ -		
	System Back-up and Storage Plan	$ -		
	UAT Training Plan	$ -	$ -	
	Summary of Transition Changes Report	$ -	$ -	
Total Fixed *Price of all OIP Design Deliverables (Enter amount in Schdule A(N), Month 5, Sch-B(N) Price)				$ -
OIP Construction Deliverables				

	State of Alabama **Medicaid Management Information System** **SCHEDULE B(N) - To be complete by Non-Incumbent Vendor Only**			
	OPERATIONS IMPLEMENTATION PHASE (OIP) DELIVERABLES			
	All deliverables must be "APPROVED" by the Medicaid ITB Project Manager and/or the Executive Steering Committee before payment is made to the Awarded Vendor on a deliverable. The deliverables below are to be priced based on the Bidder's bid for the final approved deliverable within each stage. Enter bid price in column D. The total fixed price on any one phase cannot exceed 25 percent of the cost for the entire Operations Implementation Phase			
OIP PHASE	**DELIVERABLES**	**DELIVERABLE FIXED PRICE**	**TOTAL FIXED PRICE**	
	Construction		$ -	
	Peer Reviews and Walk-through documents	$ -		
	Unit and Subsystem Test Results	$ -		
	OIP Implementation Plan	$ -	$ -	
	Updated Design Documents		$ -	
	Updated System Support and Transition Design Documents	$ -		
	Updated Operations Support and Transition Design Documents	$ -		
	Updated Summary of Transition Changes Report	$ -		
	Draft Manuals and documentation	$ -	$ -	
	Training Plan	$ -	$ -	
	UAT Training	$ -	$ -	
	Mock Data Conversion Results	$ -	$ -	
	Disaster Recovery/Business Continuity Plar	$ -	$ -	
	Test Plans	$ -	$ -	
	Vendor Certification in writing that the AMMIS is ready for the test phase	$ -	$ -	

	State of Alabama **Medicaid Management Information System** **SCHEDULE B(N) - To be complete by Non-Incumbent Vendor Only**			
	OPERATIONS IMPLEMENTATION PHASE (OIP) DELIVERABLES			
	All deliverables must be "APPROVED" by the Medicaid ITB Project Manager and/or the Executive Steering Committee before payment is made to the Awarded Vendor on a deliverable. The deliverables below are to be priced based on the Bidder's bid for the final approved deliverable within each stage. Enter bid price in column D. The total fixed price on any one phase cannot exceed 25 percent of the cost for the entire Operations Implementation Phase			
OIP PHASE	**DELIVERABLES**	**DELIVERABLE FIXED PRICE**	**TOTAL FIXED PRICE**	
Total Fixed *Price of all OIP Construction Deliverables (Enter amount in Schdule A(N), Month 7, Sch-B(N) Price)				$ -
OIP Test Phase Deliverables				
	System Test Results	$ -	$ -	
	Parallel Test Results	$ -	$ -	
	User Acceptance Test Complete	$ -	$ -	
	Regression Test Results	$ -	$ -	
	Stress Test Results	$ -	$ -	
	Vendor Certification that the AMMIS is fully functional	$ -	$ -	
Total Fixed *Price of all OIP Test Phase Deliverables (Enter amount in Schdule A(N), Month 10, Sch-B(N) Price)				$ -

	State of Alabama **Medicaid Management Information System** **SCHEDULE B(N) - To be complete by Non-Incumbent Vendor Only**			
	OPERATIONS IMPLEMENTATION PHASE (OIP) DELIVERABLES			
	All deliverables must be "APPROVED" by the Medicaid ITB Project Manager and/or the Executive Steering Committee before payment is made to the Awarded Vendor on a deliverable. The deliverables below are to be priced based on the Bidder's bid for the final approved deliverable within each stage. Enter bid price in column D. The total fixed price on any one phase cannot exceed 25 percent of the cost for the entire Operations Implementation Phase			
OIP PHASE	**DELIVERABLES**	**DELIVERABLE FIXED PRICE**	**TOTAL FIXED PRICE**	
OIP Implementation Phase Deliverables				
	Final Preprations for going productior		$ -	
	Conduct final Data conversion	$ -		
	Prepare and deliver notice to providers concerning transition activities	$ -		
	Conduct Provider Training	$ -		
	Conduct training for Vendor and Agency Staff	$ -		
	Distribute Alabama unique forms	$ -		
	Prepare, print or burn and deliver all user, system and provider manuals and documentation	$ -		
	Final Version of all Deliverables, documentation and manuals	$ -		
	Conduct Call Center and Support Training	$ -		
	Ensure the AMMIS has the most current version of software and data	$ -		
	Completion of all activities in the training and implementation plans	$ -		
	Completion of all OIP deliverables	$ -		

	State of Alabama **Medicaid Management Information System** **SCHEDULE B(N) - To be complete by Non-Incumbent Vendor Only**			
	OPERATIONS IMPLEMENTATION PHASE (OIP) DELIVERABLES			
	All deliverables must be "APPROVED" by the Medicaid ITB Project Manager and/or the Executive Steering Committee before payment is made to the Awarded Vendor on a deliverable. The deliverables below are to be priced based on the Bidder's bid for the final approved deliverable within each stage. Enter bid price in column D. The total fixed price on any one phase cannot exceed 25 percent of the cost for the entire Operations Implementation Phase			
OIP PHASE	**DELIVERABLES**	**DELIVERABLE FIXED PRICE**	**TOTAL FIXED PRICE**	
	Installation of the Manuals and Documentation System Operations Procedures on-line or on the web.	$ -		
	Begin Production Processing		$ -	
	Control and Store Transition-period claims	$ -		
	Begin Processing Claims for all claim types	$ -		
	Post Implementation Deliverables		$ -	
	Approval of AMMIS financial data and claims inventory balancing procedures	$ -		
	Approval that all claims types are processing at expected volumes and within the required time frames	$ -		
	Approval that all reports are being delivered as required	$ -		
Total Fixed *Price of all OIP Implementation Phase Deliverables (Enter amount in Schdule A(N), Month 11, Sch-B(N) Price)				$ -

	State of Alabama **Medicaid Management Information System** **SCHEDULE B(N) - To be complete by Non-Incumbent Vendor Only**			
	OPERATIONS IMPLEMENTATION PHASE (OIP) DELIVERABLES			
	All deliverables must be "APPROVED" by the Medicaid ITB Project Manager and/or the Executive Steering Committee before payment is made to the Awarded Vendor on a deliverable. The deliverables below are to be priced based on the Bidder's bid for the final approved deliverable within each stage. Enter bid price in column D. The total fixed price on any one phase cannot exceed 25 percent of the cost for the entire Operations Implementation Phase			
OIP PHASE	**DELIVERABLES**	**DELIVERABLE FIXED PRICE**	**TOTAL FIXED PRICE**	
Grand Total Fixed Price for OIP and EIP				$ -
* The total fixed price on any one phase cannot exceed 25 percent of the cost for the entire Operations Implementation Phase				
	Signature:_____	Date:_____		

	State of Alabama **Medicaid Management Information System** **SCHEDULE B(N) - To be complete by Non-Incumbent Vendor Only**			
	OPERATIONS IMPLEMENTATION PHASE (OIP) DELIVERABLES			
	All deliverables must be "APPROVED" by the Medicaid ITB Project Manager and/or the Executive Steering Committee before payment is made to the Awarded Vendor on a deliverable. The deliverables below are to be priced based on the Bidder's bid for the final approved deliverable within each stage. Enter bid price in column D. The total fixed price on any one phase cannot exceed 25 percent of the cost for the entire Operations Implementation Phase			
OIP PHASE	**DELIVERABLES**	**DELIVERABLE FIXED PRICE**	**TOTAL FIXED PRICE**	

	State of Alabama **Medicaid Management Information System** **SCHEDULE B(N) - To be complete by Non-Incumbent Vendor Only**			
	ENHANCEMENTS IMPLEMENTATION PHASE (EIP) DELIVERABLES			
EIP PHASE	All deliverables must be "APPROVED" by the Medicaid ITB Project Manager and/or the Executive Steering Committee before payment is made to the Awarded Vendor on a deliverable. The deliverables below are to be priced based on the Bidder's bid for the final approved deliverable within each stage. Enter the bid price in column D. The total fixed price on any one phase cannot exceed 25 percent of the cost for the entire Enhancements Implementation Phase	**DELIVERABLE FIXED PRICE**	**TOTAL FIXED PRICE**	
EIP Startup Deliverables	**DELIVERABLES**			
	Final Work Plan		$ -	
	Project Organization and Staffing Plan	$ -		
	Risk Management Plan	$ -		
	Communication Plan	$ -		
	Security Plan	$ -		
	Detailed Implementation Schedule	$ -	$ -	
	Master Test Plan	$ -	$ -	
	Project Charter		$ -	
	Project Kick-off Meeting	$ -		
	Project Orientation	$ -		
	Quality Management Plan	$ -	$ -	
	Issue Management Plan	$ -	$ -	
	Deliverable Definition Documents	$ -	$ -	
	Bi-Weekly Status Reports	$ -	$ -	
	Enhancement Plan		$ -	
	Configuration Management Plan	$ -		
	Requirements Traceability Matrix	$ -	$ -	
Total Fixed *Price of all EIP Startup Phase Deliverables (Enter amount in Schdule A(N), Month 13, Sch-B(N) Price)				$ -

	State of Alabama **Medicaid Management Information System** **SCHEDULE B(N) - To be complete by Non-Incumbent Vendor Only**			
	ENHANCEMENTS IMPLEMENTATION PHASE (EIP) DELIVERABLES			
EIP PHASE	All deliverables must be "APPROVED" by the Medicaid ITB Project Manager and/or the Executive Steering Committee before payment is made to the Awarded Vendor on a deliverable. The deliverables below are to be priced based on the Bidder's bid for the final approved deliverable within each stage. Enter the bid price in column D. The total fixed price on any one phase cannot exceed 25 percent of the cost for the entire Enhancements Implementation Phase	**DELIVERABLE FIXED PRICE**	**TOTAL FIXED PRICE**	
EIP Requirements Definition Deliverables				
	Enhancement Design Documents	$ -	$ -	
	JAD Sessions		$ -	
	JAD Meeting Minutes	$ -		
	Requirements document for each enhancement	$ -		
	Updated ITB requirements	$ -		
	Detail Design Document		$ -	
	Enhancement Detail Design Documents	$ -		
	Ancillary enhancement Design Detail Documents	$ -		
	Data Conversion Documents	$ -	$ -	
	Summary of Enhancement Changes Report	$ -	$ -	
Total Fixed *Price of all EIP Requirements Definition Phase Deliverables (Enter amount in Schdule A(N), Month 14, Sch-B(N) Price)				$ -
EIP Construction Deliverables				
	Construction		$ -	
	Peer Reviews and Walk-through documents	$ -		

	State of Alabama **Medicaid Management Information System** **SCHEDULE B(N) - To be complete by Non-Incumbent Vendor Only**			
	ENHANCEMENTS IMPLEMENTATION PHASE (EIP) DELIVERABLES			
EIP PHASE	All deliverables must be "APPROVED" by the Medicaid ITB Project Manager and/or the Executive Steering Committee before payment is made to the Awarded Vendor on a deliverable. The deliverables below are to be priced based on the Bidder's bid for the final approved deliverable within each stage. Enter the bid price in column D. The total fixed price on any one phase cannot exceed 25 percent of the cost for the entire Enhancements Implementation Phase	**DELIVERABLE FIXED PRICE**	**TOTAL FIXED PRICE**	
	Unit and Subsystem Test Results	$ -		
	Training Plan	$ -	$ -	
	EIP Implementation Plan	$ -	$ -	
	System Documentation		$ -	
	Draft Manuals and documentation	$ -		
	Test Plans	$ -	$ -	
	Vendor Certification in writing that the AMMIS is ready for the test Phase	$ -	$ -	
Total Fixed *Price of all EIP Contruction Phase Deliverables (Enter amount in Schdule A(N), Month 15, Sch-B(N) Price)				$ -
EIP Test Phase Deliverables				
	System Test Results	$ -	$ -	
	User Acceptance Test Complete	$ -	$ -	
	Regression Test Results	$ -	$ -	
	Stress Test Results	$ -	$ -	
Total Fixed *Price of all EIP Test Phase Deliverables (Enter amount in Schdule A(N), Month 17, Sch-B(N) Price)				$ -

	State of Alabama **Medicaid Management Information System** **SCHEDULE B(N) - To be complete by Non-Incumbent Vendor Only**			
	ENHANCEMENTS IMPLEMENTATION PHASE (EIP) DELIVERABLES			
EIP PHASE	All deliverables must be "APPROVED" by the Medicaid ITB Project Manager and/or the Executive Steering Committee before payment is made to the Awarded Vendor on a deliverable. The deliverables below are to be priced based on the Bidder's bid for the final approved deliverable within each stage. Enter the bid price in column D. The total fixed price on any one phase cannot exceed 25 percent of the cost for the entire Enhancements Implementation Phase	**DELIVERABLE FIXED PRICE**	**TOTAL FIXED PRICE**	
EIP Implementation Phase Deliverables				
	Final Preparations		$ -	
	Final Version of all Deliverables	$ -		
	Ensure the AMMIS has the most current version of software and data	$ -		
	Prepare and deliver notice to providers concerning transition activities	$ -		
	Conduct Provider Training	$ -		
	Conduct training for Vendor and Agency Staff	$ -		
	Conduct Call Center and Support Training	$ -		
	Distribute Alabama unique forms	$ -		
	Prepare, print or burn and deliver all user, system and provider manuals and documentation	$ -		
	Final update to all documentation	$ -		
	Completion of all activities in the training and implementation plans	$ -		
	Completion of all EIP deliverables	$ -		
	Installation of the Manuals and Documentation System Operations Procedures on-line or on the web.	$ -		

	State of Alabama **Medicaid Management Information System** **SCHEDULE B(N) - To be complete by Non-Incumbent Vendor Only**			
	ENHANCEMENTS IMPLEMENTATION PHASE (EIP) DELIVERABLES			
EIP PHASE	All deliverables must be "APPROVED" by the Medicaid ITB Project Manager and/or the Executive Steering Committee before payment is made to the Awarded Vendor on a deliverable. The deliverables below are to be priced based on the Bidder's bid for the final approved deliverable within each stage. Enter the bid price in column D. The total fixed price on any one phase cannot exceed 25 percent of the cost for the entire Enhancements Implementation Phase	**DELIVERABLE FIXED PRICE**	**TOTAL FIXED PRICE**	
	Implement Enhancements		$ -	
	Begin Processing Claims for all claim types	$ -		
	Agency acceptance of Enhancements	$ -		
	Post Implementation Deliverables		$ -	
	Approval of AMMIS financial data and claims inventory balancing procedures	$ -		
	Approval that all claims types are processing at expected volumes and within the required time frames	$ -		
	Approval that all reports are being delivered as required	$ -		
Total Fixed *Price of EIP Implementation Phase Deliverables (Enter amount in Schdule A(N), Month 18, Sch-B(N) Price)				$ -
Grand Total Fixed Price of all EIP Phases				$ -

	State of Alabama **Medicaid Management Information System** **SCHEDULE B(N) - To be complete by Non-Incumbent Vendor Only**			
	ENHANCEMENTS IMPLEMENTATION PHASE (EIP) DELIVERABLES			
EIP PHASE	All deliverables must be "APPROVED" by the Medicaid ITB Project Manager and/or the Executive Steering Committee before payment is made to the Awarded Vendor on a deliverable. The deliverables below are to be priced based on the Bidder's bid for the final approved deliverable within each stage. Enter the bid price in column D. The total fixed price on any one phase cannot exceed 25 percent of the cost for the entire Enhancements Implementation Phase	**DELIVERABLE FIXED PRICE**	**TOTAL FIXED PRICE**	
* The total fixed price on any one phase cannot exceed 25 percent of the cost for the entire Enhancements Implementation Phase				
	Signature:_____	Date:_____		

	State of Alabama **Medicaid Management Information System** **SCHEDULE B(N) - To be complete by Non-Incumbent Vendor Only**			
	ENHANCEMENTS IMPLEMENTATION PHASE (EIP) DELIVERABLES			
EIP PHASE	All deliverables must be "APPROVED" by the Medicaid ITB Project Manager and/or the Executive Steering Committee before payment is made to the Awarded Vendor on a deliverable. The deliverables below are to be priced based on the Bidder's bid for the final approved deliverable within each stage. Enter the bid price in column D. The total fixed price on any one phase cannot exceed 25 percent of the cost for the entire Enhancements Implementation Phase	**DELIVERABLE FIXED PRICE**	**TOTAL FIXED PRICE**	

State of Alabama
Medicaid Management Information System
Pricing Schedule C(N)
Operations Cost
Pricing Schedule C(N) - To be completed by Non-Incumbent Vendor Only

Year	Item	Price
1	Base Price Per Month **Total Monthly Price (Enter amount on Sch. A(N), Months 19-30, Sch-C(N) Price**)	$ -
2	Base Price Per Month **Total Monthly Price (Enter amount on Sch. A(N), Months 31-42, Sch-C(N) Price)**	$ -
3	Base Price Per Month **Total Monthly Price (Enter amount on Sch. A(N), Months 43-54, Sch-C(N) Price)**	$ -
4	Base Price Per Month **Total Monthly Price (Enter amount on Sch. A(N), Months 55-66, Sch-C(N) Price)**	$ -
5	Base Price Per Month **Total Monthly Price (Enter amount on Sch. A(N), Months 67-78, Sch-C(N) Price)**	$ -
6	Base Price Per Month **Total Monthly Price (Enter amount on Sch. A(N), Months 89-90, Sch-C(N) Price)**	$ -
7	Base Price Per Month **Total Monthly Price (Enter amount on Sch. A(N), Months 91-102, Sch-C(N) Price)**	$ -

*** For Evaluation Purposes Only.**

Signature:_____ Date:_____

State of Alabama
Medicaid Management Information System

Pricing Schedule D(N)
Summary Extra Contractural Services

Year 1 From Pricing Schedule D-2	$ -	Box 1
Average Monthly Cost (Divide Amount in Box 1 by 12)	$ -	Box 2
Enter Amount from Box 2 to Schedule A(N), Months 19-30		
Year 2 From Pricing Schedule D-3	$ -	Box 3
Average Monthly Cost (Divide Amount in Box 3 by 12)	$ -	Box 4
Enter Amount from Box 4 to Schedule A(N), Months 31-42		
Year 3 From Pricing Schedule D-4	$ -	Box 5
Average Monthly Cost (Divide Amount in Box 5 by 12)	$ -	Box 6
Enter Amount from Box 6 to Schedule A(N), Months 43-54		
Year 4 From Pricing Schedule D-5	$ -	Box 7
Average Monthly Cost (Divide Amount in Box 7 by 12)	$ -	Box 8
Enter Amount from Box 8 to Schedule A(N), Months 55-66		
Year 5 From Pricing Schedule D-6	$ -	Box 9
Average Monthly Cost (Divide Amount in Box 9 by 12)	$ -	Box 10
Enter Amount from Box 10 to Schedule A(N), Months 67-78		
Year 6 From Pricing Schedule D-7	$ -	Box 11
Average Monthly Cost (Divide Amount in Box 11 by 12)	$ -	Box 12
Enter Amount from Box 12 to Schedule A(N), Months 79-90		
Year 7 From Pricing Schedule D-8	$ -	Box 13
Average Monthly Cost (Divide Amount in Box 13 by 12)	$ -	Box 14
Enter Amount from Box 14 to Schedule A(N), Months 91-102		
TOTAL EXTRA CONTRACTURAL SERVICES COSTS (Informational Only)	$ -	
(Sum of Boxes 1, 3, 5, 7, 9,11, and 13)		

Signature: _____ Date: _____

State of Alabama
Medicaid Management Information System

Pricing Schedule D-2
Extra Contractual Services - Contract Year 1

	Personnel Category	Hourly Rate	Hours (See Note)	Evaluated Cost
1	EIS/DSS Technical Support	$ -	1,500	$ -
2	Senior Systems Analyst	$ -	1,500	$ -
3	Programmer Analyst	$ -	2,500	$ -
4	Junior Programmer Analyst	$ -	1,500	$ -
5	Project Analyst	$ -	3,500	$ -
6	Customer Relations Staff	$ -	2,000	$ -
7	Systems/Technical Support	$ -	250	$ -
8	Professional Staff (Nurses)	$ -	250	$ -
9	CPU Time	$ -	500	$ -

TOTAL EXTRA CONTRACTUAL SERVICES COSTS EXTENSION 1:	**$ -**

Enter on Sch-D-1, Box 1.

Note: Hours indicated are for evaluation purposes only.

Signature: _____ Date: _____

State of Alabama
Medicaid Management Information System

Pricing Schedule D-3
Extra Contractual Services - Contract Year 2

	Personnel Category	Hourly Rate	Hours (See Note)	Evaluated Cost
1	EIS/DSS Technical Support	$ -	1,500	$ -
2	Senior Systems Analyst	$ -	1,500	$ -
3	Programmer Analyst	$ -	2,500	$ -
4	Junior Programmer Analyst	$ -	1,500	$ -
5	Project Analyst	$ -	3,500	$ -
6	Customer Relations Staff	$ -	2,000	$ -
7	Systems/Technical Support	$ -	250	$ -
8	Professional Staff (Nurses)	$ -	250	$ -
9	CPU Time	$ -	500	$ -

TOTAL EXTRA CONTRACTUAL SERVICES COSTS EXTENSION 1:	**$ -**

Enter on Sch-D-1, Box 3.

Note: Hours indicated are for evaluation purposes only.

Signature: _____ Date: _____

State of Alabama
Medicaid Management Information System

Pricing Schedule D-4
Extra Contractual Services - Contract Year 3

	Personnel Category	Hourly Rate	Hours (See Note)	Evaluated Cost
1	EIS/DSS Technical Support	$ -	1,500	$ -
2	Senior Systems Analyst	$ -	1,500	$ -
3	Programmer Analyst	$ -	2,500	$ -
4	Junior Programmer Analyst	$ -	1,500	$ -
5	Project Analyst	$ -	3,500	$ -
6	Customer Relations Staff	$ -	2,000	$ -
7	Systems/Technical Support	$ -	250	$ -
8	Professional Staff (Nurses)	$ -	250	$ -
9	CPU Time	$ -	500	$ -

TOTAL EXTRA CONTRACTUAL SERVICES COSTS EXTENSION 1:	**$ -**

Enter on Sch-D-1, Box 5.

Note: Hours indicated are for evaluation purposes only.

Signature: _____ Date: _____

State of Alabama
Medicaid Management Information System

Pricing Schedule D-5
Extra Contractual Services - Contract Year 4

	Personnel Category	Hourly Rate	Hours (See Note)	Evaluated Cost
1	EIS/DSS Technical Support	$ -	1,500	$ -
2	Senior Systems Analyst	$ -	1,500	$ -
3	Programmer Analyst	$ -	2,500	$ -
4	Junior Programmer Analyst	$ -	1,500	$ -
5	Project Analyst	$ -	3,500	$ -
6	Customer Relations Staff	$ -	2,000	$ -
7	Systems/Technical Support	$ -	250	$ -
8	Professional Staff (Nurses)	$ -	250	$ -
9	CPU Time	$ -	500	$ -

TOTAL EXTRA CONTRACTUAL SERVICES COSTS EXTENSION 1:	**$ -**

Enter on Sch-D-1, Box 7.

Note: Hours indicated are for evaluation purposes only.

Signature: _____ Date: _____

State of Alabama
Medicaid Management Information System

Pricing Schedule D-6
Extra Contractual Services - Contract Year 5

	Personnel Category	Hourly Rate	Hours (See Note)	Evaluated Cost
1	EIS/DSS Technical Support	$ -	1,000	$ -
2	Senior Systems Analyst	$ -	1,000	$ -
3	Programmer Analyst	$ -	2,000	$ -
4	Junior Programmer Analyst	$ -	1,000	$ -
5	Project Analyst	$ -	2,000	$ -
6	Customer Relations Staff	$ -	2,000	$ -
7	Systems/Technical Support	$ -	250	$ -
8	Professional Staff (Nurses)	$ -	250	$ -
9	CPU Time	$ -	500	$ -

TOTAL EXTRA CONTRACTUAL SERVICES COSTS EXTENSION 1:	**$ -**

Enter on Sch-D-1, Box 9.

Note: Hours indicated are for evaluation purposes only.

Signature: _____ Date: _____

State of Alabama
Medicaid Management Information System

Pricing Schedule D-7
Extra Contractual Services - Contract Year 6

	Personnel Category	Hourly Rate	Hours (See Note)	Evaluated Cost
1	EIS/DSS Technical Support	$ -	1,000	$ -
2	Senior Systems Analyst	$ -	1,000	$ -
3	Programmer Analyst	$ -	2,000	$ -
4	Junior Programmer Analyst	$ -	1,000	$ -
5	Project Analyst	$ -	2,000	$ -
6	Customer Relations Staff	$ -	2,000	$ -
7	Systems/Technical Support	$ -	250	$ -
8	Professional Staff (Nurses)	$ -	250	$ -
9	CPU Time	$ -	500	$ -

TOTAL EXTRA CONTRACTUAL SERVICES COSTS EXTENSION 1:	**$ -**

Enter on Sch-D-1, Box 11.

Note: Hours indicated are for evaluation purposes only.

Signature: _____ Date: _____

State of Alabama
Medicaid Management Information System

Pricing Schedule D-8
Extra Contractual Services - Contract Year 7

	Personnel Category	Hourly Rate	Hours (See Note)	Evaluated Cost
1	EIS/DSS Technical Support	$ -	1,000	$ -
2	Senior Systems Analyst	$ -	1,000	$ -
3	Programmer Analyst	$ -	2,000	$ -
4	Junior Programmer Analyst	$ -	1,000	$ -
5	Project Analyst	$ -	2,000	$ -
6	Customer Relations Staff	$ -	2,000	$ -
7	Systems/Technical Support	$ -	250	$ -
8	Professional Staff (Nurses)	$ -	250	$ -
9	CPU Time	$ -	500	$ -

TOTAL EXTRA CONTRACTUAL SERVICES COSTS EXTENSION 1:	**$ -**

Enter on Sch-D-1, Box 13.

Note: Hours indicated are for evaluation purposes only.

Signature: _____ Date: _____